Non-PHI

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COMMONWEALTH of VIRGINIA

Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797
NELSON SMITH, COMMISSIONER

State Human Rights Committee Meeting

November 3, 2022
DBHDS
REGION 3
Southern Virginia Mental Health Institute
382 Taylor Drive
Norman Auditorium
Danville, Virginia
24541

This is an on-site meeting. Those wishing to attend virtually can join via Zoom.
Join ZoomGov Meeting
https://dbhds.zoomgov.com/j/1617839100

Meeting ID: 161 783 9100
Passcode: $HRCMet1ng
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Meeting ID: 161 783 9100
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AGENDA

November 3, 2022 SHRC Meeting
9:00 a.m.

9:00	**Call to Order**	Julie C. Allen, SHRC Chair
	Welcome from Chairperson Allen Introductions	
	Approval of Agenda	
	Review of Draft Minutes September 29, 2022	
	Information	
9:15	**Welcome and Overview of Programs/Services**	Robin Crews, Facility Director Southern Virginia Mental Health Institute
9:30	**Public Comment Period**	Julie C. Allen, SHRC Chair
9:35	**Variance** Central State Hospital Request for Variances	Brandi Justice, Facility Director, CSH Jennifer Barker, Director of Patient Relations, CSH Tony Davis, Human Rights Advocate
10:00	**Appeal**	Cheryl Young Human Rights Advocate
	Deliberation	
11:00	**VCBR** Follow Up from VCBR Complaint CHRIS #20220084 DI 205 VCBR FI 131	Tony Davis Human Rights Advocate
11:30	**OHR Facility Operations Updates** Seclusion, Restraint & Death Data Violation Letters VCBR Reports	Mary Clair O'Hara, Associate Director, Facility Operations Brandon Charles, Facility Operations Manager Tony Davis, Human Rights Advocate
12:00	**OHR Community Operations Update**	Jennifer Kovack, Accociate Director, Community Operations
	BREAK	
12:30	**LHRC Business** LHRC Application Revision LHRC Liaison Reporting	Julie C. Allen, Chair Taneika Goldman, SHRD

Appointments

Region 2

NVH LHRC

NVR LHRC

Region 3

Virginia Highlands LHRC

Facilities

Staunton Area LHRC

Draft 2023 Meeting Schedule — Taneika Goldman

Subcommittees — Julie Allen

Policy Subcommittee — David Boehm
David Boehm; Betty Crance; Mary Clair O'Hara, Staff

Workplan Subcommittee — Will Childers
David Crews

Bylaws Subcommittee — Monica Lucas
Monica Lucas, Chair; Jennifer Kovack, Staff

LHRC Bylaws Template

HR Access

Membership Subcommittee — Timothy Russell
Will Childers, David Crews

Officer Subcommittee — Will Childers
Timothy Russell

Other — Julie Allen/Taneika Goldman

Adjournment — Julie Allen

Next Meeting

December 8, 2022
Piedmont Geriatric Hospital
Burkeville, Virginia

COMMONWEALTH of VIRGINIA
Department of Behavioral Health and Developmental Services
Post Office Box 1797
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State Human Rights Committee Meeting
VIRTUAL MEETING
DRAFT Minutes
Thursday, September 29, 2022
DBHDS
Northwestern Community Services Board
209 West Criser Road, Suite 300
Boardroom
Front Royal, Virginia
22630

Zoom for Government
https://dbhds.zoomgov.com/j/1617839100
Meeting ID: 161 783 9100
Passcode: $HRCMet1ng

Convene
9:00 a.m.

SHRC Members Present Physically	David Boehm, **Vice-Chair**; Will Childers; David Crews, Monica Lucas, Timothy Russell
SHRC Members Present Virtually	Julie C. Allen, **Chair**; Betty Crance;
Staff Present Physically	Taneika Goldman, State Human Rights Director Mary Clair O'Hara, Associate Director for Facility Operations Artea Ambrose, Human Rights Advocate Heather Hilleary, Human Rights Advocate Kli Kinzie, Executive Secretary

Staff Attending Virtually	Karen A. Taylor, Senior Assistant Attorney General, Counsel to the SHRC Dev Nair, Assistant Commissioner Jennifer Kovack, Associate Director for Community Operations Brandon Charles, Facility Operations Manager Cassie Purtlebaugh, Regional Advocate Manager, Region 1 Reginald T. Daye, Regional Advocate Manager, Region 5 Tony Davis, Human Rights Advocate Latoya Wilborne, Human Rights Advocate Corie Reed, Human Rights Advocate Angela Dodson, Human Rights Advocate Richard Wright, Director, Office of Forensic Services Jennifer Barker, Director of Patient Relations, Central State Hospital
Others Present Physically	Dawn Van Metre, next to monica Alex Waddell, Special Project Manager & Human Rights Advocate, Northwestern Community Services Board Jennifer Spangler, Concerned Citizen Steven Gray, Concerned Citizen
Others Attending Virtually	Rebecca Herbig, Disability Rights Advocate, disAbility Law Center of Virginia, (dLCV) Ren Faszewski, Disability Rights Advocate, dLCV Mr. Riddick, Patient, Central State Hospital Sheldon Ekirch, Fellow, dLCV Jen Sykes, Mother and Legal Guardian of OB Devon Sykes, Father of OB Kerry Kruk, Team Lead Coordinator, Virginia Beach Department of Human Services (VB DHS) Stacy O'Toole, Behavioral Health Services Division Administrator, VB DHS Melissa W, Mother of JTA Stewart Prost, Human Rights Consultant Brandi Justice, Facility Director, Central State Hospital Jennifer Barker, Director Patient Relations and Recovery Initiatives, Central State Hospital
Call to Order	At 9:15, David Boehm, SHRC Vice-Chair, called the September 29, 2022, SHRC meeting to order and welcomed everyone to the meeting. A call for introductions took place prior to proceeding.
Approval of Agenda	At 9:20, the committee considered the agenda. Julie Allen, SHRC Chair, acknowledged and thanked David Boehm for facilitating the meeting due to her participation being virtual. *At 9:20, a motion was made by Timothy Russell and seconded by David Crews to approve the September 29, 2022 agenda. David Boehm, SHRC Vice-Chair, called for votes in roll call fashion. All members voted to pass the motion.*

Review of Draft Minutes

At 9:22, the SHRC reviewed the draft minutes of the August 18, 2022, meeting. Timothy Russell proposed corrections to subcommittee membership.

At 9:22, a motion was made by David Crews and seconded by Monica Lucas to approve the August 18, 2022, minutes as corrected. David Boehm, SHRC Vice-Chair, called for votes in roll call fashion. All members voted to pass the motion.

Information

At 9:22, Taneika Goldman, State Human Rights Director, addressed the Committee.

Commissioner Message

At 9:23, Taneika Goldman, State Human Rights Director, shared Commissioner Smith's Weekly Message dated September 11, 2022, with the Committee. Commissioner Smith's message highlighted SHRC member Will Childers. *(See addendum 1).*

Variance Updates

At 9:24, Taneika Goldman acknowledged annual updates to variances previously approved by the Committee from The Barry Robinson Center, Holiday House of Portsmouth, Virginia Beach Department of Human Services (Pathways), Newport News Behavioral Health Center, Harbor Point Behavioral Health Center and Kempsville Center for Behavioral Health. These reports have been presented to the programs respective LHRCs. There were no concerns reported by Reginald T. Daye, Regional Advocate Manager, Region 5. R. Daye was present virtually to answer any questions from the Committee.

SHRC 2021 Annual Executive Summary

At 9:25, Taneika Goldman briefed the Committee on the SHRC 2021 Annual Executive Summary. The Executive Summary was presented to the DBHDS State Board by Taneika Goldman and Julie C. Allen, SHRC Chair, on July 13, 2022. Mrs. Goldman provided a high-level overview of the report to the Board, enumerating some of the activities of last year. Mrs. Goldman also shared with the Board information on the structure of the Office of Human Rights.

Public Comment Period

At 9:34, David Boehm called for public comments. A call for introductions took place prior to proceeding.

At 9:35, Jennifer Spangler and Steven Gray, Interested Citizens, gave public comments and provided a written version of the public comments made, along with dLCV reports and other articles for reference. *(See addendum 2).*

At 9:40, Mr. Riddick, Patient, Central State Hospital, gave public comments and voiced his concerns about human rights protections.

Welcome and Overview

At 9:49, Mike Elwell, Executive Director, Northwestern Community Services Board, welcomed the Committee and provided an overview of the CSB programs and the populations served in the area. The Committee was especially interested to hear about the drug courts and the success rate of the CSB's behavioral health docket for recovery treatment case management.

BREAK At 10:08, David Boehm called for a brief break.

At 10:15, the meeting reconvened. A call for introductions took place prior to proceeding.

Appeal At 10:15, the SHRC considered the Appeal of Northwestern LHRC Findings in the Matter of OB v Community Alternatives of Virginia. This Appeal was postponed from the August 18, 2022, SHRC meeting due to technical difficulties. The SHRC honored the request of Jen Sykes, Mother and Legal Guardian of OB, to hear the appeal in open session.

Parties to the Appeal Jen Sykes was present virtually along with Devon Sykes, Father of OB, to represent the individual, OB. SHRC members present in person were David Boehm, Vice Chair; Will Childers; David Crews; Monica Lucas: and Timothy Russell. SHRC members present virtually were Julie Allen, Chair; and Betty Crance. Also present in person were Taneika Goldman, State Human Rights Director; Mary Clair O'Hara, Human Rights Associate Director of Facility Operations; Artea Ambrose, Human Rights Advocate, Heather Hilleary, Human Rights Advocate and Kli Kinzie, Executive Secretary.
Also present virtually were Karen Taylor, Senior Assistant Attorney General and Counsel to the SHRC; Jennifer Kovack, OHR Associate Director of Community Operations; and Cassie Purtlebaugh, Regional Advocate Manager for Region 1.

Closed Session *At 10:42, upon a motion by Will Childers the SHRC convened in closed session pursuant to VA CODE § 2.2-3711 (A) (4) (8) and (16), for the protection of the privacy of individuals in personal matters not related to public business, discussion of their medical records, and for consultation with legal counsel regarding specific legal matters requiring the provision of legal advice by such counsel.*

Upon a motion by Will Childers, the SHRC returned to open session. Upon reconvening in open session each member certified that, to the best of their knowledge, only matters lawfully exempted from open meeting requirements and only such matters related to the stated reason for going into closed session were heard, discussed, or considered.

The SHRC's written response will be issued to all parties within 20 working days.

LHRC Business At 11:27, the SHRC considered LHRC business.

LHRC Membership At 11:28, Taneika Goldman reported a resignation and presented recommendations for appointments to LHRCs. Discussion followed regarding residency of LHRC applicants. Further discussion was tabled until later in the meeting.

Appeal

At 11:40, the Committee considered the Appeal of Health Planning Region 5 LHRC in the Matter of JTA v Virginia Beach Department of Human Services. The SHRC honored the request of Stewart Prost on behalf of JTA to hear the appeal in open session.

Stewart Prost, Human Rights Consultant, was present to represent Melissa W on behalf of JTA. SHRC members present in person were David Boehm, Vice-Chair; Will Childers; David Crews; Monica Lucas; and Timothy Russell. SHRC Members Julie Allen, Chair; and Betty Crance were present virtually. Also present in person were Taneika Goldman, State Human Rights Director; Mary Clair O'Hara, Human Rights Associate Director of Facility Operations; and Kli Kinzie, Executive Secretary. Also present virtually were Karen Taylor, Senior Assistant Attorney General and Counsel to the SHRC; Jennifer Kovack, OHR Associate Director of Community Operations; Reginald T. Daye, Regional Human Rights Manager for Region 5; Corie Reed, Human Rights Advocate; Latoya Wilborne, Human Rights Advocate; Angela Dodson, Human Rights Advocate; Kerry Kruk, Team Lead Coordinator, Virginia Beach Department of Human Services (VB DHS); and Stacy O'Toole, Behavioral Health Services Division Administrator, VB DHS..

Closed Session

At 12:09, upon a motion by Will Childers the SHRC convened in closed session pursuant to VA CODE § 2.2-3711 (A) (4) (8) and (16), for the protection of the privacy of individuals in personal matters not related to public business, discussion of their medical records, and for consultation with legal counsel regarding specific legal matters requiring the provision of legal advice by such counsel.

At 12:36, upon a motion by Timothy Russell, the SHRC returned to open session. Upon reconvening in open session each member certified that, to the best of their knowledge, only matters lawfully exempted from open meeting requirements and only such matters related to the stated reason for going into closed session were heard, discussed, or considered.

Deliberation will continue later in the meeting. The SHRC's written response will be issued to all parties within 20 working days.

VCBR Follow Up on Appeals

At 12:37, Jason Wilson, Facility Director, Virginia Center for Behavioral Rehabilitation, talked about VCBR's private messaging system and about the facility's process for filing criminal charges. This review was in follow-up to Complaint Appeal 20220047 and Complaint Appeal 20220084.

Variance Request

At 1:08, the SHRC considered a Variance request from Central State Hospital. Jennifer Barker, Director Patient Relations and Recovery Initiatives, Central State Hospital, presented the request with Facility Director Brandi Justice.

A discussion followed relating to the proposed Variances and public comments made earlier in the meeting. The Committee deferred its decision on the Variance request to its November 3, 2022, meeting. Monica Lucas recommended CSH be provided copies of information provided during public comment for their review and feedback to the SHRC.

LHRC Membership (continued)

At 1:35, the Committee continued its deliberation of the issue of whether LHRC members must be residents of Virginia.

At 1:49, upon a motion by Betty Crance and seconded by David Boehm the SHRC acknowledged the resignation of Mary Ann Gray from Rappahannock-Rapidan LHRC. All members voted to pass the motion.

At 1:50, upon a motion by David Crews and seconded by Will Childers the SHRC appointed Patricia Albritton to the Southeastern Regional LHRC by a vote of 6:1. Julie Allen, David Boehm, Will Childers, David Crews and Monica Lucas voted to make the appointment. Timothy Russell voted against the motion. Betty Crance voted to approve the motion with comments.

At 1:53, upon a motion by Monica Lucas and seconded by David Crews the Committee voted to appoint Stacy Johnson to the Southeastern Regional LHRC. All members voted to pass the motion.

Betty Crance recommended that Taneika Goldman draft guidance on LHRC member screening criteria and residency requirements for the SHRC to review at the November 3, 2022 meeting. Taneika Goldman offered to present a draft revised LHRC application.

Closed Session

At 1:54, upon a motion by Will Childers and seconded by David Crews the SHRC convened in closed session pursuant to VA CODE § 2.2-3711 (A) (4) (8) and (16), for the protection of the privacy of individuals in personal matters not related to public business, discussion of their medical records, and for consultation with legal counsel regarding specific legal matters requiring the provision of legal advice by such counsel.

Upon a motion by Will Childers, the SHRC returned to open session. Upon reconvening in open session each member certified that, to the best of their knowledge, only matters lawfully exempted from open meeting requirements and only such matters related to the stated reason for going into closed session were heard, discussed, or considered.

Facility Operation Updates	At 2:09, David Boehm called for Facility Operation Updates. Taneika Goldman reported that Brandon Rotenberry has legally changed his name to Brandon Charles. Mrs. Goldman thanked Riley Curran, Human Rights Advocate, and Brandon Charles, Facility Advocate Manager, for covering the vacant Human Rights Advocate position at Northern Virginia Mental Health Institute (NVMHI).
NVMHI	At 2:09, Riley Curran provided an overview of NVMHI, including seclusion and restraint data, allegations of abuse, and complaints. *(See addendum 3).*
S/R & Death	At 2:13, Mary Clair O'Hara presented seclusion, restraint and death data. *(See addendum 4).*
Violation Letters	At 2:32, Brandon Charles presented a summary of violation letters. *(See addendum 5).*
VCBR	At 2:35, Tony Davis provided an update on VCBR complaints, seclusion and restraint and allegations of abuse. *(See addendum 6).*
LHRC Liaison Reporting	At 2:43, Will Childers reported on an LHRC meeting he attended in Culpeper. A discussion followed on the dynamics of meetings and the lack of a feeling of connection when meetings are held completely virtually. Betty Crance commented that it is helpful when providers present on their programs and services. Taneika Goldman discussed plans for orientation of LHRC members. Timothy Russell asked for a place on the web site for information about the different types of providers.
Sub-committees	At 2:52, David Boehm called for Sub-Committee reports.
Policy Subcommittee	David Boehm; Betty Crance; Mary Clair O'Hara, Staff *Nothing to report at this time.*
Workplan Subcommittee	David Crews Timothy Russell has stepped down from the Workplan Subcommittee. *Nothing further to report at this time.*
Membership Subcommittee	Will Childers and David Crews At 11:50, Timothy Russell reported on membership changes. The Subcommittee is now comprised of Will Childers along with David Crews. Mr. Russell offered to send out the Virginia map showing distribution of SHRC members. Taneika Goldman will ask regional managers for recommendations for SHRC membership. Interviews will be conducted during the December 8 meeting in Burkeville.

Bylaws Subcommittee	Monica Lucas, Chair; Jennifer Kovack, Staff *Nothing to report at this time.*
Officer Subcommittee	Officer Subcommittee: Timothy Russell. *Nothing to report at this time.*
2023 Meeting Schedule	At 3:10, the Committee considered a draft 2023 meeting schedule. Discussion of 2023 meeting dates and locations will be on the November 3, 2022 meeting agenda.
Adjournment	At 3:16, having no further business to discuss the September 29, 2022, SHRC meeting adjourned.

Next Meeting
November 3, 2022
Southern Virginia Mental Health Institute
Danville
Region 1

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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Office of Human Rights

August 17, 2022

Julie Allen, Chairperson
State Human Rights Committee
P.O. Box 1797
Richmond, VA 23218-1797

SUBJECT: Variances requested by Central State Hospital

Chairperson Allen,

In compliance with 12VAC35-115-220 (C)(2) I am submitting the variance application for Central State Hospital (CSH) to the State Human Rights Committee.

Attached you will find CSH's variance application, including supporting documents, to following sections of the *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Behavioral Health and Developmental Services* (Human Rights Regulations):

- **12 VAC35-115-50 (C)(6)(a)(7)(a) – Dignity**

  The requested variance to (C)(6)(a) will allow CSH to open, but not read mail and packages in the presence of non-forensic patients in maximum security forensic programs (Building 39). The requested variance to (C)(7)(a) does not allow patients in maximum security forensic programs (Building 39) to communicate among themselves by mail or telephone.

- **12 VAC35-115-100 (A)(1)(c) – Restrictions on freedoms of everyday life**

  The requested variance will provide non-forensic patients with the opportunity to purchase items in a canteen within the secure perimeter and from external providers. However, patients in these units are not permitted to retain money on their person within the secure perimeter.

- **12 VAC35-115-20 (A)(2) – Policy, 12 VAC35-115-50 (C)(3)(a) – Dignity**

The requested variance will allow CSH to require routine "pat-downs" of fully clothed non-forensic patients in secure programs: (1) before and after group movement within the secure perimeter; (2) anytime a patient leaves the secure perimeter; or (3) anytime a patient has physical access to a visitor who is not an employee of CSH. This will also allow CSH to conduct proactive routine searches of patients' bedroom areas to identify contraband or safety and security breaches.

- **12 VAC35-115-150 – General Provisions, 12 VAC35-115-175 – Human Rights Complaint Process; 12 VAC35-115-180 – LHRC Hearing and Review Procedures; 12 VAC35-115-190 – Special Procedures for Emergency Hearing by LHRC; 12 VAC35-115-200 – Special Procedures for LHRC Reviews Involving Consent and Authorization**

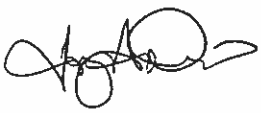
  This variance establishes the Maximum Security Appeals Committee, and allows the forensic patients of CSH (Building 39) to file a final appeal directly to the Maximum Security Appeals Committee in lieu of the LHRC.

On May 19, 2022, the Tri-City LHRC reviewed and voted to recommend approval of CSH's variance requests with the following recommendations:

- Approval of the variance for a three-year period upon which CSH will return to the LHRC with quarterly updates.

I would like to recommend approval of the above referenced variance requests and the Tri-City LHRC recommendations.

Thank you,



Tony A. Davis, MS
DBHDS Office of Human Rights
Human Rights Advocate

CC: Taneika Goldman, State Human Rights Director, DBHDS OHR
Mary Clair O'Hara, Associate Director for Facility Operations, DBHDS OHR
Brandon Rotenberry, MSW, Facility Advocate Manager, DBHDS OHR

Attachments:

- Commissioner Approval
- TCLHRC Variance Request Approval
- Variance Request Document

Commonwealth of Virginia

Department of Behavioral Health and Developmental Services

Central State Hospital

Brandi P. Justice, Psy.D.

Memorandum

To: Nelson Smith., Commissioner, DBHDS

From: Brandi P. Justice, Psy. D, Director/CEO, CSH

RE: Request for Approval to Apply for Variances to 12 VAC 35-115

April 5, 2022

Central State Hospital (CSH) is requesting your approval to apply to the CSH Local Human Rights Committee (LHRC) and the State Human Rights Committee (SHRC) for variances to the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Behavioral Health and Developmental Services (Human Rights Regulations). For a number of years, the DBHDS Commissioner has approved Central State Hospital (CSH) to make application for these variances. I am hereby requesting your approval to apply for the triennial renewal of each of our existing and proposed variances (listed below), as required by section 12 VAC 35-115-220, Variances, B., of the Human Rights Regulations. I have also attached draft copies of the applications for variances, summarized below:

1. CSH's maximum security practice of opening, but not reading, mail in front of civil patients in secure forensic programs. Along with a restriction on patients within the maximum security unit communicating with each other by telephone or email.

2. CSH's maximum security practice of prohibiting civil patients from retaining any form of money on their person in secure forensic programs.

3. CSH's maximum security practice of conducting routine "pat downs" of fully clothed civil patients and searches of patients' bedroom areas in secure forensic programs.

4. CSH's maximum security complaint resolution process which allows for individuals not satisfied with the CSH Director's response, to appeal to the CSH Maximum Security Appeals Committee.

Thank you for your consideration of this request.

Central State Hospital (CSH) Requested Variances to the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services 12 VAC 35-115-10 et seq.

Variance No. One

Mail

I. Variance to Section:

12 VAC 35-115-50, Dignity, C6, "each individual has the right to communicate privately with any person by mail and have help in writing or reading as needed."

12 VAC 35-115-50, Dignity, C6 (a), contains a narrow exception to this right should there be "reasonable cause to believe that the mail contains illegal material or anything dangerous. If so, the director or their designee may open the mail, but not read it, in the presence of the individual."

12 VAC 35-115-50, Dignity, C7, "each individual has the right to communicate privately with any person by telephone and have help in doing so."

12 VAC 35-115-50, Dignity, C7 (a), contains a narrow exception to this right "if, in the judgment of a licensed professional, communication with another person or persons will result in demonstrable harm to the individual or significantly affect his treatment."

II. Proposed Procedure(s):

Central State Hospital (CSH) opens but does not read mail and packages in the presence of non-forensic patients in maximum security forensic programs (Building 39). CSH does not allow patients in maximum security forensic programs (Building 39) to communicate among themselves by mail or telephone.

III. Justification for the Variance:

All of the individuals admitted to the maximum security forensic programs are assessed to present a level of risk for injury to themselves or others and/or a potential risk for escape that exceeds the ability of a locked civil facility to safely manage. The vast majority of these individuals are transferred directly from jail under Title 19.2 for the purpose of receiving evaluation or treatment. However, a number of individuals within secure forensic programs are civilly committed directly from the Department of Corrections or remain in a secure program under a civil commitment status after being found unrestorably incompetent to stand trial and/or following the dismissal of their criminal charges. Such individuals are routinely reassessed for appropriateness for transfer to a less restrictive treatment setting. If their level of risk precludes such a transfer, they are managed in a manner consistent with the overall level of risk that justifies continuing treatment in a secure forensic setting.

CSH cannot fulfill its duty to provide a safe environment for high-risk patients in secure forensic programs through less intrusive means than opening mail and packages in the presence of patients in secure forensic programs. Likewise, CSH cannot fulfill its duty to provide a safe environment if patients are permitted to communicate with each other via telephone and mail within the secure environment. These communications have resulted in an increasing number of situations in which patients have used these means to plan aggression against staff and other patients; and/or engage in other illegal activities. Staff supervision is sufficient when patients gather for meals and group treatment to making communication for illicit behavior difficult. Less restrictive attempts have been made to deter planful acts of violence without success.

The ability for patients to call and write from one ward to another poses significant dangers, as these private conversations serve as a means to plot harm to others. Concerns increase that patients will use these private communication routes to plot an escape, riot, hostage situation, or other organized illegal action.

CSH's practice of opening mail and packages in the presence of patients continues to result in the discovery of contraband concealed by "non-suspicious" looking envelopes and packages:

- Lighters, knives, and cigarettes located in patients' personal property at the time of admission;
- Pills sewn into clothing hems;
- Extremely explicit photographs of individuals in suggestive possesses of varying ages;
- A dozen or more matches torn from a matchbook tucked inside the flaps of a cardboard box;
- Tennis shoes with metal in the soles;
- Various powdered substances are folded with the sheets of paper in an envelope.

CSH's maximum security forensic program had a longstanding practice of requiring patients to open mail in front of a staff member. This variance was sought following the Commissioner requesting that the Department of Corrections appoint an individual to participate in a security audit of the Hospital's secure forensic programs in March of 2000. Following this audit, in a Memorandum dated April 12, 2000, the DOC Auditor recommended, "the patients should not open the package in front of staff, but that the staff should open the package in front of the patient" since it is not uncommon for criminal defendants and convicted offenders to receive contraband through the mail. Some of these individuals are highly skilled and effective in secreting contraband. Permitting such individuals to open their mail and packages provides an otherwise avoidable opportunity for a patient to secure contraband for later use as a weapon or tool to affect an escape.

On November 21, 2019, the State Human Rights Committee approved this variance for three years. The Hospital continues to provide the Local Human Rights Committee updates on implementing this variance. There have been no reported concerns, human rights complaints, or unusual events relating to implementing this variance during the past three years.

IV. Duration of the Requested Variance:

Three years with continuing updates to the LHRC.

Variance No. Two

Money

I. Variance to Section:

12 VAC 35-115-100, Restriction on freedom of everyday life, A1(c), "each individual entitled to the freedom to have and spend personal money."

II. Proposed Procedures:

CSH's secure forensic unit (Building 39) provides non-forensic patients with the opportunity to purchase items in a canteen within the secure perimeter and from external providers. However, patients in these units are not permitted to retain money on their person within the secure perimeter.

III. Justification for the Variance:

All individuals admitted to secure forensic programs are assessed to present a level of risk for injury to themselves or others and/or a potential risk for escape that exceeds the ability of a locked civil facility to safely manage. The vast majority of these individuals are transferred directly from jail under Title 19.2 for the purpose of receiving evaluation or treatment. However, a number of individuals within secure forensic programs are civilly committed directly from the Department of Corrections or remain in a secure program under a civil commitment status after being found unrestorably incompetent to stand trial and/or following the dismissal of their criminal charges. Such individuals are routinely reassessed for appropriateness for transfer to a less restrictive treatment setting. In the event their level of risk precludes such a transfer, they are managed in a manner that is consistent with the overall level of risk that justifies continuing treatment in a secure setting.

CSH's secure forensic program has a longstanding practice of prohibiting the personal possession of any form of money within the secure perimeter. However, patients are provided with opportunities to purchase items in a canteen within the secure perimeter and from external providers. This forensic security practice reduces the likelihood of: (a) coins being used as weapons or to compromise the security and surveillance system; and (b) the use of cash to facilitate an escape by either forensic or non-forensic patients.

On November 21, 2019, the State Human Rights Committee approved this variance for three years. The Hospital continues to provide the Local Human Rights Committee updates on implementing this variance. There have been no reported concerns, human rights complaints, or unusual events relating to implementing this variance during the past three years.

IV. Duration of the Requested Variance:

Three years with continuing updates to the LHRC.

Variance No. Three

Pat downs

I. Variance to Sections:

12 VAC 35-115-20, Policy, A2 "Each individual who receives services shall be assured respect for basic human dignity."

12 VAC 35-115-50 C 3(a), Dignity, "each individual has the right to ... reasonable privacy..."

II. Proposed Procedures:

Central State Hospital's (CSH) forensic security practice requires routine "pat-downs" of fully clothed non-forensic patients in secure programs: (1) before and after group movement within the secure perimeter; (2) anytime a patient leaves the secure perimeter; or (3) anytime a patient has physical access to a visitor who is not an employee of CSH. CSH also conducts proactive routine searches of patients' bedroom areas to identify contraband or safety and security breaches.

III. Justification for the Variance:

All individuals admitted to secure forensic programs are assessed to present a level of risk for injury to themselves or others and/or a potential risk for escape that exceeds the ability of a locked civil facility to safely manage. The vast majority of these individuals are committed for evaluation or treatment under Title 19.2. However, a number of individuals are civilly committed directly from the Department of Corrections or remain in a secure program under a civil commitment status after being found unrestorably incompetent to stand trial and/or following the dismissal of their criminal charges. Such individuals are routinely reassessed for appropriateness for transfer to a less restrictive treatment setting. In the event their level of risk precludes such a transfer, they are managed in a manner that is consistent with the overall level of risk that justifies continuing treatment in a secure setting.

CSH cannot fulfill its duty to provide a safe environment for high-risk patients in secure forensic programs through less intrusive means than routine "pat-downs" of fully clothed patients and proactive searches of patients' bedroom areas. CSH cannot identify contraband's presence on a patient's person through external visual inspection alone because bulky clothing, pockets, and body crevices make it reasonably easy to conceal items that can be used as a weapon to injure one or others. Such contraband can then be hidden in areas of the patients' bedrooms for later use.

Routine security "pat-downs" and bedroom searches have disclosed the following kinds of contraband that were not identifiable by external visual inspection:

- combs that had been sharpened into shanks;
- pen inserts that can be used as an instrument to stab another person;
- plastic spoons that have been broken and sharpened into shanks;

- drill bits that had been hidden among a patient's personal property in their bedroom;
- paper clip and batteries from a Walkman fashioned into a lighter;
- surgical scissors removed from a doctor's office and hidden in the patient's groin area to smuggle into the building;
- plastic deodorant and/or razor blade tops that are used to lacerate oneself and others;
- wooden splinters, sections of grouting, and plastic or metal pieces that have been removed from the walls and furniture;
- parts and pieces of board games, Walkman radios, and cassette tapes.

This variance was sought following the Commissioner requesting that the Department of Corrections appoint an individual to participate in a security audit of the Hospital's secure forensic programs in March of 2000. Following this audit, in a Memorandum dated April 12, 2000, the DOC Auditor recommended, CSH conduct routine "pat-downs" of all fully clothed patients in secure forensic units (a) before and after group movement within the secure perimeter; (b) anytime a patient leaves the secure perimeter, or (c) anytime a patient has physical access to a visitor who is not an employee of CSH. CSH also conducts proactive routine searches of patients' bedroom areas in the patient's presence to identify contraband or breaches of safety and security. Some of CSH's patients are highly skilled in obtaining contraband from external sources and creating weapons from materials and/or objects within the secure perimeter. CSH's practice of routine "pat-downs" and searches is essential to the safety and security of staff and patients and to maintaining the integrity of the secure perimeter.

On November 21, 2019, the State Human Rights Committee approved this variance for three years. The Hospital continues to provide the Local Human Rights Committee updates on implementing this variance. There have been no reported concerns, human rights complaints, or unusual events relating to the implementation of this variance during the past three years.

V. Duration of the Requested Variance:

Three years with continuing updates to the LHRC.

Variance No. Four

Complaint Process

I. Variance to Sections:

12 VAC 35-115-150: General Provisions

12 VAC 35-115-1 75: Human Rights Complaint Process

12 VAC 35-115-180: Local Human Rights Committee Hearing and Review Procedures

12 VAC 35-115-190: Special Procedures for Emergency Hearing by LHRC

12 VAC 35-115-200: Special Procedures for LHRC Reviews Involving Consent and Authorization

II. Proposed Procedures:

12 VAC 35-115-150: General Provisions

A resident who has followed the procedures of CSH RTS-01d Patient and Family Complaint Resolution and is not satisfied with the CSH Director's response may appeal the decision to the CSH Maximum Security Appeals Committee.

The CSH Maximum Security Appeals Committee consists of the Chairperson and Vice-Chair of the State Human Rights Committee and the Department of Behavioral Health and Developmental Services (DBHDS) Director of Human Rights. If neither the Chair nor Vice-Chair of the committee is a consumer of services, a consumer member of the SHRC will be appointed to the Appeals Committee.

The CSH Maximum Security Appeals Committee shall review the appeal and provide a written response within 21 days. If the Appeals Committee determines the complaint to be a founded complaint. The response, which includes recommendations outlining how the complaint should be resolved, shall be forwarded to the director for resolution.

A copy shall be sent to the human rights advocate. This is the final level of appeal.

12 VAC 35-115-175: Human Rights Complaint Process

A. Anyone who believes that the provider has violated an individual's rights under these regulations may report it to the director or the human rights advocate for resolution.

i. The procedures outlined in CSH Policy RTS-01d, Patient and Family Complaint Resolution, shall be followed if a complaint is pursued.

B. If at any time the human rights advocate concludes there is a substantial risk that serious or irreparable harm will result if the complaint is not resolved immediately, the human rights

advocate shall inform the director and the CSH Maximum Security Appeals Committee and the DBHDS Director of Human Rights. The CSH Maximum Security Appeals Committee shall review the issue within 72 hours of receiving this information.

12 VAC 35-115-180: Local Human Rights Committee Hearing and Review Procedures

A. Any individual or their authorized representative who disagrees with the director's final decision or action plan resulting from any complaint resolution process may request a review by the CSH Maximum Security Appeals Committee.

B. The individual or his authorized representative must file the request for review by the CSH Maximum Security Appeals Committee within ten days of the director's action or final decision on the complaint.

1. The appeal request must be in writing on the form designated by CSH Policy RTS-01d Patient and Family Complaint Resolution. It should contain all facts and arguments surrounding the complaint and reference any section of the regulations that the individual believes the provider violated.

2. The human rights advocate and any individual other than another resident of CSH may help the individual in filing the appeal. If the individual chooses a person other than the human rights advocate to help them, their chosen representative may request the human rights advocate's assistance in filing the appeal.

C. The CSH Maximum Security Appeals Committee shall review the appeal and provide a written response within 21days. If the Appeals Committee determines the complaint to be a founded complaint, the response, which includes recommendations outlining how the complaint should be resolved, shall be forwarded to the director for resolution. A copy shall be sent to the human rights advocate. This is the final level of appeal.

12 VAC 35-115-190: Special Procedures for Emergency Hearing by LHRC

A. If the human rights advocate informs the CSH Maximum Security Appeals Committee of a substantial risk that serious and irreparable harm will result if a complaint is not resolved immediately, the CSH Maximum Security Appeals Committee shall review the issue within 72 hours of receiving the information.

1. The director or his designee and the human rights advocate shall be available to discuss the issue with the CSH Maximum Security Appeals Committee.

2. The review shall be concluded on an expedited basis.

B. At the end of the review, the CSH Maximum Security Appeals Committee shall make preliminary findings and, if a violation is found, shall make preliminary recommendations to the director.

C. The director shall formulate and carry out an action plan within 24 hours of receiving the CSH Maximum Security Appeal Committee's recommendations. A copy of the plan shall be sent to the human rights advocate, the individual, and his authorized representative.

12 VAC 35-115-200: Special Procedures for LHRC Reviews Involving Consent and Authorization

A. The individual, his authorized representative, or anyone acting on the individual's behalf may request in writing that the CSH Maximum Security Appeals Committee review the following situations and issue a decision:

1. If an individual or their authorized representative objects at any time to the appointment of a specific person as an authorized representative or any decision for which consent or authorization is required and has been given by their authorized representative, other than a legal guardian, they may ask the Appeals Committee to decide whether the capacity was evaluated correctly, the authorized representative was appointed correctly, or the authorized representative's decision was made based on the individual's fundamental values and any preferences previously expressed by the individual to the extent that they are known, and if unknown or unclear in the individual's best interests.

a. The provider shall take no action for which consent or authorization is required if the individual objects, except in an emergency or as otherwise permitted by law, pending the Appeals Committee review.

b. If the Appeals Committee determines that the individual's capacity was evaluated correctly, the authorized representative is appropriately designated, or the authorized representative's decision was made based on the individual's fundamental values and any preferences previously expressed by the individual to the extent that they are known, or if unknown or unclear in the individual's best interests, then the provider may proceed according to the decision of the authorized representative.

c. If the Appeals Committee determines that the individual's capacity was not properly evaluated or the authorized representative was not properly designated, then the provider shall take no action for which consent is required except in an emergency or as otherwise required or permitted by law, until the capacity review and authorized representative designation is appropriately done.

d. If the Appeals Committee determines that the authorized representative's decision was not made based on the individual's basic values and any preferences previously expressed by the individual to the extent known and if unknown or unclear, in the individual's best interests, then the provider shall take steps to remove the authorized representative pursuant to 12VAC35-115-146.

2. If an individual or his family member has obtained an independent evaluation of the individual's capacity to consent to treatment or services or to participate in human research, or authorize the disclosure of information under 12VAC35-115-80, and the

opinion of that evaluator conflicts with the opinion of the provider's evaluator, the Appeals Committee may be requested to decide which evaluation will control.

a. If the Appeals Committee agrees that the individual lacks the capacity to consent to treatment or services or authorize the disclosure of information, the director may begin or continue treatment or research or disclose information, but only with the appropriate consent or authorization of the authorized representative.

b. If the Appeals Committee disagrees that the individual lacks the capacity to consent to treatment or services or authorize the disclosure of information, the director shall not begin any treatment or research, or disclose information without the individual's consent or authorization, or shall take immediate steps to discontinue any actions begun without the consent or authorization of the individual.

3. If the director makes a decision that affects an individual and the individual believes that the decision requires their consent or authorization or that of his authorized representative, he may object and ask the Appeals Committee to decide whether consent or authorization is required. Regardless of the individual's capacity to consent to treatment or services or authorize disclosure of information, if the Appeals Committee determines that a decision made by a director requires consent or authorization that was not obtained, the director shall immediately rescind the action unless and until such consent or authorization is obtained.

C. Before making such a decision, the Appeals Committee shall review the action proposed by the director, any determination of lack of capacity, the opinion of the independent evaluator if applicable, and the individual's or his authorized representative's reasons for objecting to that determination. To facilitate its review, the Appeals Committee may ask that a physician or licensed clinical psychologist not employed by the provider evaluate the individual at the provider's expense and give an opinion about his capacity to consent to treatment or authorize information. The Appeals Committee shall notify all parties and the human rights advocate of the decision within 10 working days of the initial request.

12 VAC 35-115-210: State Human Rights Committee Appeals Procedure

Decisions of the CSH Maximum Security Appeals Committee may not be appealed.

III. Justification for the Variance:

The Human Rights Regulations provide a comprehensive complaint resolution process that includes access to a Local Human Rights Committee and the State Human Rights Committee (SHRC). The population in the maximum security forensic unit at CSH requires a more structured and shorter complaint process to better protect the residents, employees, and the public. The individuals in the maximum-security unit typically have a shorter length of stay, and most of them are admitted from and discharged to the criminal justice system. The clinical needs of these individuals are better protected by a complaint process that moves at a more rapid pace than the process provided in the Human Rights Regulations.

Individuals housed in the maximum-security unit are generally placed there because of escape risk and/or incurred serious, violent charges for which they are facing potentially lengthy sentences. While many of them have mental illnesses, it is not the symptoms of mental illness that result in the need for maximum security placement but rather criminal behavior. For this reason, addressing antisocial attitudes and behaviors is a common aspect of many individuals' treatment plans. Therefore, in October 2017, the Hospital sought this variance to provide a complaint process that fully protects individual rights but does not reinforce entitlement or criminal thinking attitudes.

On November 21, 2019, the State Human Rights Committee approved this variance for three years. The Hospital continues to provide the Local Human Rights Committee updates on implementing this variance.

There have been no reported concerns or unusual events relating to the implementation of this variance during the past three years. In April 2020, a recommendation was by a patient at CSH. This individual recommended made that the Appeals Committee have a consumer member. This change is reflected in the variance.

IV. Duration of the Requested Variance:

Three years with continuing updates to the LHRC.

VIRGINIA REGULATORY TOWN HALL

Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Back to List of Comments

Commenter: disAbility Law Center of Virginia 8/3/22 8:01 am

dLCV Public Comment on CSH Variances

dLCV Opposes All Proposed Central State Hospital Variances

The disAbility Law Center of Virginia (dLCV) supports the secure and appropriate administration of services for patients at Central State Hospital (CSH). dLCV also supports the Virginia Human Rights Regulations and the dignity that they bring to patients and people with disabilities in the state. However, dLCV opposes the variances to the Human Rights Regulations that CSH is requesting.

Variance I: Communication

CSH seeks a broad variance to the Human Rights regulations that protect a patient's right to private communications. We oppose this broad variance and urge the continued practice of seeking individual restrictions only in the circumstances described in the regulations

The Human Rights Regulations give patients the right "to communicate privately with any person by telephone." 12 VAC 35-115-50, Dignity, C7. CSH argues that it requires a variance to the Human Rights Regulations to prevent patients from plotting to escape, rioting, creating a hostage situation, or engaging in other illegal actions. CSH already has the right to limit communication if it would "result in demonstratable harm to the individual or significantly affect his treatment." 12 VAC 35-115-50, Dignity, C7 (a). Escapes, riots, and hostage situations would harm the patient or his treatment through injuries sustained during the events and disruptions in therapy and treatments, and therefore qualify under the regulations. CSH is asking for a blanket waiver, which is in violation of the spirit and intent the Human Rights Regulations. The regulations weigh the need for safety was weighed against the need for dignity in treatment. If CSH would like to limit the communication of patients that are plotting illegal activities, it should be done on an individualized basis as the regulations require.

CSH states that it had a long-standing practice of requiring patients to open their mail in front of a staff member in order to prevent contraband from being brought into the facility. This practice fits the Human Rights Regulations that give patients "the right to communicate privately with any person by mail." 12 VAC 35-115-50, Dignity, C6. The practice was ended at the suggestion of an individual from the Department of Corrections (DOC) who said it would be more secure if mail was opened by staff.

CSH should not seek a variance based on the advice of corrections officials. Patients at the hospital are not prisoners in a DOC facility. They should not be treated as such. Rather their treatment by CSH must be administered in accordance with regulations. CSH has a legal obligation to use the least restrictive method of limiting the rights of patients. Furthermore, CSH already has an exception to the regulations when there is "reasonable cause to believe that the mail contains illegal material or anything dangerous. If so, the director or their designee may open the mail, but not read it, in the presence of the individual." 12 VAC 35-115-50, Dignity, C6(a). To reiterate, the regulations balance the need for security and dignity, and CSH must seek variances to the regulations on an individual basis.

Variance II: Money

CSH seeks a broad variance, prohibiting all use of money in the forensic unit. We oppose. We urge the continued practice of seeking individual restrictions only in the circumstances described in the regulations.

Patients have the right "to have and spend personal money." 12 VAC 35-115-100, Restriction on freedom of everyday life, A1(c). CSH seeks to prohibit the possession of any form of money in the secure forensic program. The hospital states that it requires this variance in order to prevent coins from being used as weapons, as well as to prevent the use of money in facilitating an escape. CSH has an obligation to pursue alternative means before seeking a variance that completely overrules the Human Rights Regulations. Evidence has not been provided of attempts at the implementation of other less restrictive methods. A possible alternative is lockers that are controlled by patients and monitored by staff. Again, CSH must request a variance on an individual basis if they believe the individual is using money inappropriately. By requesting more restrictive measures, CSH is once again ignoring the freedoms patients are ensured under the Human Rights Regulations.

Variance III: Pat-downs

CSH seeks a broad variance to be able to do room searches and pat downs. We oppose. We urge the continued practice of seeking individual restrictions only in the circumstances described in the regulations.

Human Rights Regulations give patients the right to "basic respect for basic human dignity" and reasonable privacy. 12 VAC 35-115-20, Policy, A2 and 12 VAC 35-115-50 (C)(3a), Dignity. This language prevents pat-downs and room searches for patients. CSH seeks a variance to practice these procedures. However, the language of the proposed variance is confusing. CSH has not provided justification as to why the pat-down procedure is only being sought for non-forensic patients. It is also unclear why pat-downs are necessary for group movement within the secure perimeter, but not for individual movement. Furthermore, there is no rationale as to why the variance for searches of patients' bedrooms is generalized, while the pat-down procedure only applies to non-forensic patients. Once again, CSH should seek an individualized variance, and only for individuals who are found to have contraband. dLCV reiterates that these are patients in a treatment facility, not in a DOC facility.

Variance IV: Complaint Process

CSH seeks a broad variance, to eliminate rights of maximum security patients to be able to use the human right complaint process. We oppose this. CSH should, in fact, support the use of the process and seek limitations rarely and on an individual basis.

When a patient is in a Department of Behavioral Health and Developmental Services (DBHDS) facility and that facility violates their rights under the Human Rights Regulations, the patient first appeals to the director. 12 VAC 35-115-80 (A). If the patient does not agree with the director's final decision, they can appeal to the Local Human Rights Committee (LHRC). 12 VAC 35-115-80 (A). This decision is then appealable to the State Human Rights Committee (SHRC). 12 VAC 35-115-210. The variance that CSH is requesting will not follow this procedure for the Maximum-Security Forensic Unit. Under the variance, if a patient does not agree with the director's decision, the patient can appeal to the CSH Maximum Security Appeals Committee and should receive a written response within 21 days. The committee would consist of the Chairperson and Vice-Chair of the SHRC and the DBHDS Director of the Office of Human Rights. The decision by the CSH Appeals Committee is not appealable. CSH states that it requires the variance because the nature of the Max Forensic Unit means that the patients generally have shorter stays, so patients need a more structured and quicker complaint process.

Since CSH was granted the variance initially, there have been problems with the new complaint process. Before continuing the variance, the hospital must show how it will address the following issues: First, many patients at the facility have complained that the CSH complaint process takes longer than the 21 days that are proposed in the variance. This defeats the purpose of having a quicker process due to shorter stays. Second, the proposed variance has the possibility of leading to a greater chance of retaliation. One patient filed a complaint in federal court after he experienced retaliation from doctors at Central State Hospital for complaints that he made. *See*, Farabee v. Yaratha, No. 18-1952, 19 (4th Cir. 2020). The doctor intentionally provided another patient, known to have conflicts with the victim, greater access by keeping the two patients on the same ward with only one bed in between them and suggesting that the patient would be rewarded for attacking the victim. Farabee v. Yaratha, No. 18-1952, 19 (4th Cir. 2020). The proposed variance would only enable similar abuses within the unit, with no meaningful appeal. It is also not clear from the supporting documents how many complaints are received by the director and how many appeals are being made to the CSH Maximum Security Appeals Committee.

If the intent is really to streamline the process, CSH could seek this variance as an optional, alternative process, and offer it to all individuals, not just the Max Forensic Unit. In that event, CSH should make clear that if they elect this process, the residents are waiving their right to appeal to the LHRC and SHRC.

On All Variances

Throughout the proposed variations to the Human Rights Regulations, CSH has shown that it would prefer to treat patients as if they are prisoners. This is shocking. The hospital needs to create a more therapeutic environment for patients, rather than a prison-like environment.

The Human Rights Regulations create a careful balance between the need for security and the need for dignity and respect. There already exists a process in the regulations that give CSH the ability to override a right on an individual basis when there is a security or safety concern. This process involves approval from the LHRC in order to ensure facilities are not violating patients' human rights. A blanket variance would go against the very heart of these regulations.

The SHRC must be very concerned about CSH's request for blanket variances that lead to no oversight or accountability. The committee is tasked with ensuring that patients in DBHDS facilities are treated with respect and dignity. By giving blanket variances, the Office of Human Rights cannot oversee the actions of CSH that fall under these variances.

The SHRC should find or develop a way to receive feedback from the patients that these variances would impact. The SHRC needs to hear directly from patients as to how these variances are being followed, and their impact on the patients. Patients are not informed of the variance proposals, and the proposals are located on an obscure website that is not well known to the public and is difficult to locate. Another issue for patients is that supporting documentation must be requested via email. Patients have limited computer time and may not have the technical skills necessary to navigate this process. Due to the lack of accessibility, it is impossible for patients to participate by sharing a public opinion. The SHRC must be concerned with the lack of input from patients on the variances.

Conclusion

When asking for a variance, CSH must show that complying with the Human Rights Regulations is non-feasible and prevents the delivery of service. CSH has not shown any attempts at less restrictive methods or evidence that complying with the Human Rights Regulations is preventing the delivery of service. CSH has not met the threshold of evidence in asking for the variance. CSH is asking for a right that they already have on an individual basis, but to expand this right with no oversight or evidence of necessity. Therefore, the proposal should be denied. If you have further questions regarding our concerns, please direct them to Robert Gray, dLCV Director of Compliance and Quality Assurance, at 804-662-7188 or Robert.gray@dlcv.org.

Sincerely,

Colleen Miller
Executive Director

CommentID: **124705**

Commonwealth of Virginia

Kinzie, Kli <kli.kinzie@dbhds.virginia.gov>

Fwd: [EXTERNAL] Re: [EXTERNAL] Re: [EXTERNAL] Public comment before state human rights committee

1 message

Goldman, Taneika <taneika.goldman@dbhds.virginia.gov> Thu, Aug 18, 2022 at 8:26 AM
To: Kli Kinzie <kli.kinzie@dbhds.virginia.gov>

The attachment and email will need to be included in the September meeting packet, please

Taneika Goldman, MPA
State Human Rights Director
Virginia Department of Behavioral Health and Developmental Services
P. O. Box 1797 | 1220 Bank Street Richmond, VA 23218-1797
Phone (804) 371-0064 | Fax (833) 734 1241

The mission of the Office of Human Rights is to monitor compliance with the Human Rights Regulations by promoting the basic precepts of human dignity, managing the DBHDS Human Rights complaint resolution program and advocating for the rights of persons with disabilities in our service delivery systems.

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DBHDS webpage for COVID-19 FAQs www.dbhds.virginia.gov/covid19

---------- Forwarded message ---------
From: **Jennifer Spangler** <jalspangler@gmail.com>
Date: Wed, Aug 17, 2022 at 5:39 PM
Subject: [EXTERNAL] Re: [EXTERNAL] Re: [EXTERNAL] Public comment before state human rights committee
To: Goldman, Taneika <taneika.goldman@dbhds.virginia.gov>

Thank you. I am unable to attend tomorrow. My daughter has school orientation that cannot be rescheduled.

May the public provide written remarks? Since time is short I included them in this email and an attached document. The document cites research and was edited by Dr. Heather Zelle at UVA department of ILPPP. Would you please print it and distribute it to members tomorrow?

I look forward to working with you regarding giving public comment at next months meeting.

Kindly,
Jennifer

My statement is as follows;

Good Morning Chair and State Human Rights Committee Members,
My name is Jennifer Spangler. I live with bipolar disorder and advocate on behalf of myself and others who have been treated in inpatient psychiatric facilities.

I am concerned that patient populations within the state mental health facilities are being treated poorly as the result of a stigmatized view that we are dangerous. 75% of the general population mistakenly believes we are dangerous.

The complaints and allegations that come before this committee must be carefully considered with an understanding that employees may carry this stigmatized viewpoint and believe that we are dangerous simply because we have a mental illness or mental health challenge.

Specifically, as you see on this document, Black and African American young men decrease in the likelihood of violence after hospitalization. An individual may be hospitalized because of a crime. But with medication and quality evidence based care like CBT violent behavior or tendancies will change. Trauma based care does help with agression if it is delivered correctly.

I would also like to make the committee aware that a lack of trauma informed care and de-escalation techniques from employees contributes to many of the behaviours that contribute to critical incidents. Facilities like Eastern State Hospital that are utilizing these measures have improved critical incidents whereas other facilities like Central State Hospital see increases in incidents due to punitive measures by hospital police.

I would also like to point out that restrictions to patients leisure time also impact critical incidents. For example, the gym has been closed in Central State Hospital for some time. It is likely that without being able to exercise and have a healthy. outlet for frustration and anger incidents are more likely to occur.

I only learned of this meeting two days ago. I apologize that I am unable to attend virtually or in person. I look forward to speaking with you in person in September to provide a more detailed comment.

Thank you.

On Wed, Aug 17, 2022 at 3:26 PM Goldman, Taneika <taneika.goldman@dbhds.virginia.gov> wrote:

Hello Jennifer. Meeting locations have not been confirmed, this is on the agenda for the 8/18/22 meeting.
Public Comment is typically scheduled for 9:35A. The SHRC decides based on the number of commenters how much time to provide. I have seen this range from 2 to 5 minutes per person/agency. When you arrive to the meeting or when you log in virtually, you will be prompted to provide your name, the entity you represent (for example, you may be representing an advocacy organization or speaking for yourself as a citizen) and the general nature of your comment. At the allotted time, the Chair will recognize you by name and let you know how much time you have.

Taneika Goldman, MPA
State Human Rights Director
Virginia Department of Behavioral Health and Developmental Services
P. O. Box 1797 | 1220 Bank Street Richmond, VA 23218-1797
Phone (804) 371-0064 | Fax (833) 734 1241

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DBHDS webpage for COVID-19 FAQs www.dbhds.virginia.gov/covid19

On Wed, Aug 17, 2022 at 3:15 PM Jennifer Spangler <jalspangler@gmail.com> wrote:

Hi Taneika,
Thank you for this information. Have the meeting locations been scheduled? I would like to plan to attend in person.

Also, what time of day is the public comment period and how much time is given to each person.

Kindly,
Jennifer

On Tue, Aug 16, 2022 at 9:21 PM Goldman, Taneika <taneika.goldman@dbhds.virginia.gov> wrote:

Hello Jennifer. The CSH variance request has not officially been added to an SHRC meeting agenda yet, but I suspect it will be heard at their September 29th meeting, based on where we are in the process right now. I can certainly set a tickler to remind our Administrative Assistant to send you an email to let you know when they are actually scheduled. And, you are also able to access all SHRC meeting agendas at least 3 days prior to each scheduled meeting on the Commonwealth Calendar

The remaining SHRC meetings for 2022 are scheduled on Thursdays, as follows:
August 18th
September 29th
November 3rd
December 8th

Meeting locations will be confirmed in the actual meeting agendas; however, public portions of all meetings are also accessible virtually via Zoom for Government.

I hope this information is helpful. Please let me know if you have any other questions.

Taneika Goldman, MPA
State Human Rights Director
Virginia **D**epartment of **B**ehavioral **H**ealth and **D**evelopmental **S**ervices
P. O. Box 1797 | 1220 Bank Street Richmond, VA 23218-1797
Phone (804) 371-0064 | Fax (833) 734 1241

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DBHDS webpage for COVID-19 FAQs www.dbhds.virginia.gov/covid19

On Tue, Aug 16, 2022 at 3:17 PM Jennifer Spangler <jalspangler@gmail.com> wrote:

Dear Taneika,
Would you please let me know the meeting where the variances Central State Hospital requested will go before the committee?

I appreciate Ruth Anne sending me your way. I did not realize this was not coming before the state board.

Kindly,
Jennifer

--
--
Jennifer Spangler, MS
LinkedIn.com/in/JALSpangler/

MentalIllnessStigmaIsDevastating.pdf
118K

The Stereotype of Dangerousness has Devastating Effects

The impact of stigma

When public perceptions and policies regarding mental illness are shaped by highly publicized but infrequent instances of gun violence toward strangers, they are unlikely to help people with mental illnesses or to improve public safety.

Policies made focusing on dangerousness as a way to generate public funding:

- Increase use of legally ordered preventative detention in a mental hospital and adherence to treatment in the community
- Deny civil rights
- Loosen standards for public reporting of protected health information

What does this mean

Given that

- Virginia, according to Mental Health America's ranking, is 39th in the nation for adult unmet need of access to mental health treatment services,
- 70% of young adults view inpatient hospitalization negatively which creates lack of trust of adults and providers, and
- Being hospitalized against one's will places an individual at risk for future involuntary hospitalization:

The problem in Virginia is not that people with mental illness are refusing care. It is that the current treatment is viewed negatively and other forms of treatment do not exist or are inaccessible.

Given that childhood abuse is an indicator for violence, a push for automatic parental notification of involuntary hospitalization of adult children could increase risk of violence.

Expansion of coercive forms of treatment such as conservatorship, which was suggested earlier this year, must undergo robust evaluation to protect people who live with mental illness from public and structural stigma bias.

The takeaway

To ensure laws benefit the health of Virginians living with mental illness, careful examination of the impact of public and structural stigma must inform policymakers as they change and create behavioral health policy.

Using public stigma of dangerousness as a method to gain approval for increased spending on mental health negatively impacts people living with mental illnesses and their caregivers and communities.

Solutions to create evidence-based mental health public policy

Admit we are all affected by stigma whether we have a mental illness diagnosis or not.

Then,

1. Reach out to constituents and ask them about their experiences in your CSBs, in private provider psychiatric units and state hospitals,
2. Hire a stigma expert to advise proposed policies, and
3. Execute an anti-stigma campaign that is led by a stigma expert, targets youth and the media, and, avoids stigmatized beliefs that mental illness is caused by neurobiology or stress

Are people who have mental illnesses dangerous

No.

According to three decades of scientific research the link between violence and mental illness is weak and indirect.

In fact:

- Most perpetrators of violent crimes do not have serious mental illnesses such as schizophrenia and bipolar disorder;
- African American young men decreased in likelihood of violence after hospitalization;
- Violence is rarely caused by psychosis, thus is not likely to be reduced through medication;
- The likelihood of engaging in gun violence did not differ between persons with and without a history of psychiatric hospitalization; and
- Gun violence perpetrators with a previous psychiatric hospitalization were not more likely to have multiple victims or to engage in mass shootings.

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9/29/22

Central State Hospital Requested Variances
Recommendations and Statement from Steven Gray

Variance 1
Patients have been talking on the phone for years. Leading to many altercations. At this time patients are talking on the phone about their rights and educating others. Now they want to limit their contact. They already have authority to put patients on phone restriction. Limiting phone access, and zoom meetings, to the outside is bad enough. To restrict patients from advocating for one another and educate each other's about current events regarding their human rights is against the law.

Variance 2
Concerning money, patients would give staff money and staff aren't professional enough to handle new circumstances. There have been many occasions where patients were found with cellular phones, alcohol, cigarettes, and drugs. The security of the facility is already compromised, money will only make that compromise worse.

The money also could be used by patients to hurt themselves like swallowing them.

Variance 3
Story of Marshall

After what happened to Marshall, I believe room searches and pat downs need to be on an individual basis. He isn't the only one that's has getting in altercations with security during unit searches.

Taking privacy from all people they mentioned, would create an environment of further hopelessness that will not be good for patients or staff.

Variance 4

Generally
Almost all of the altercations can be prevented and avoided if staff would communicate effectively. There needs to be more social interaction and unity to lift people's spirits. Giving patients more to do will improve the negative environment. Using de-escalation techniques instead of intermuscular injections and medicine would be helpful. Displaying more verbal encouragement and demonstrating patience and compassion towards patients will improve morale and lessen altercations. Being treated kindly will encourage patients to be kind. Being helped when you need help will also provide a better environment for patients and staff.

Central State Hospital is worse than the trauma I had as a child. It can be your worst nightmare at times, for many of the patients and staff alike. Sometimes it can be the most hilarious place ever. There are more bad days than good. The oppression and neglect from the facility itself can be heart breaking.

Depression will settle in just at the mere sight of your living circumstance. If that isn't enough, security and staff assault patients. They crowd around during altercations and hit patients in the body so they don't leave marks on their faces. At times security and staff assault, stalk, and wait for the moment to harass patients. The weak get hurt the most, the strong will hurt as well.

Staff who are kind have no power. The only thing necessary for evil to triumph is for good men to do nothing. Even the doctors can't stop the violence.

Medication can make the situation even worse. Side effects make it difficult to think or move. I've been over medicated and seen other over medicated individuals pass out. Patients and staff step over and around them. Some walk around not knowing the place or time, pants falling down, and drooling. The next day if the doctor is reasonable their medication will be lowered or changed. Other times this goes on for weeks, months - I'm not sure if they ever stop with some patients.

If found incompetent, the judge will take all your rights. This tactic is universal and used in many forms. CSH is the worst hospital in Virginia for the most part and depending on your treatment team, administration, and staff. Patients' treatment is case by case and patients are told to mind their business. Any form of resistance will lead to retaliation from staff and documenting your "lack of insight." Lack of insight, makes you incompetent. Round and round we go.

The good human right advocates and peer support specialist hands are tied. In most cases human right advocates do nothing. Too many people suffer, the law is being broken and sad to say it's the most vulnerable who are victimized.

This cannot continue.

9/29/22

Good Morning Madame Chair and State Human rights committee members.
My name is Jennifer Spangler. I live well with bipolar disorder. I am a concerned citizen speaking on behalf of myself and others who require inpatient hospitalization.

I request that the you deny Central State Hospital's requested variances based on data on self-injurious behavior at Central State and current research.

I believe these requested variances are well intended from the executive director's experience in the Department of Corrections. However, this is a hospital. As I hope to portray today, these punitive measures will increase current problems rather than solve them.

I have provided three years of critical incident reports from the designated federal protection and advocacy organization for people with mental illnesses, dLCV. Please note that self-injurious behavior has increased dramatically in the last year at Central State Hospital. dLCV reports that current resources being spent on self-injurious behavior (SIB) may be misplaced and points to the need of Trauma Informed Care.

I believe that staff training, provider accountability to deliver evidence-based trauma informed treatment like cognitive behavioral and dialectical behavioral therapy, and ensuring patients have access to healthy ways to manage stress like exercise, social engagement, and the outdoors will provide the therapeutic environment to achieve the results intended from these punitive measures.

Leisure, exercise and diet, self-esteem, spirituality, relationships and more are vital to a person's emotional well-being. The hospital needs to give patients a reason to live and avoid hopelessness so that patients don't exhibit behaviors because they perceive they have nothing left to lose.

CSH is already able to do all the requested variances on an individual basis.

Central State Hospital already has variances to Human Rights from other facilities. Patients seeking to file complaints have to pass through the in-house public safety department and the director before they can move forward.

Patients are requesting weekly unannounced visits from outside parties to address complaints that when reported to central state hospital treatment teams never get outside of the hospital itself. Patients are also requesting that the code of ethics be strictly enforced to protect patients.

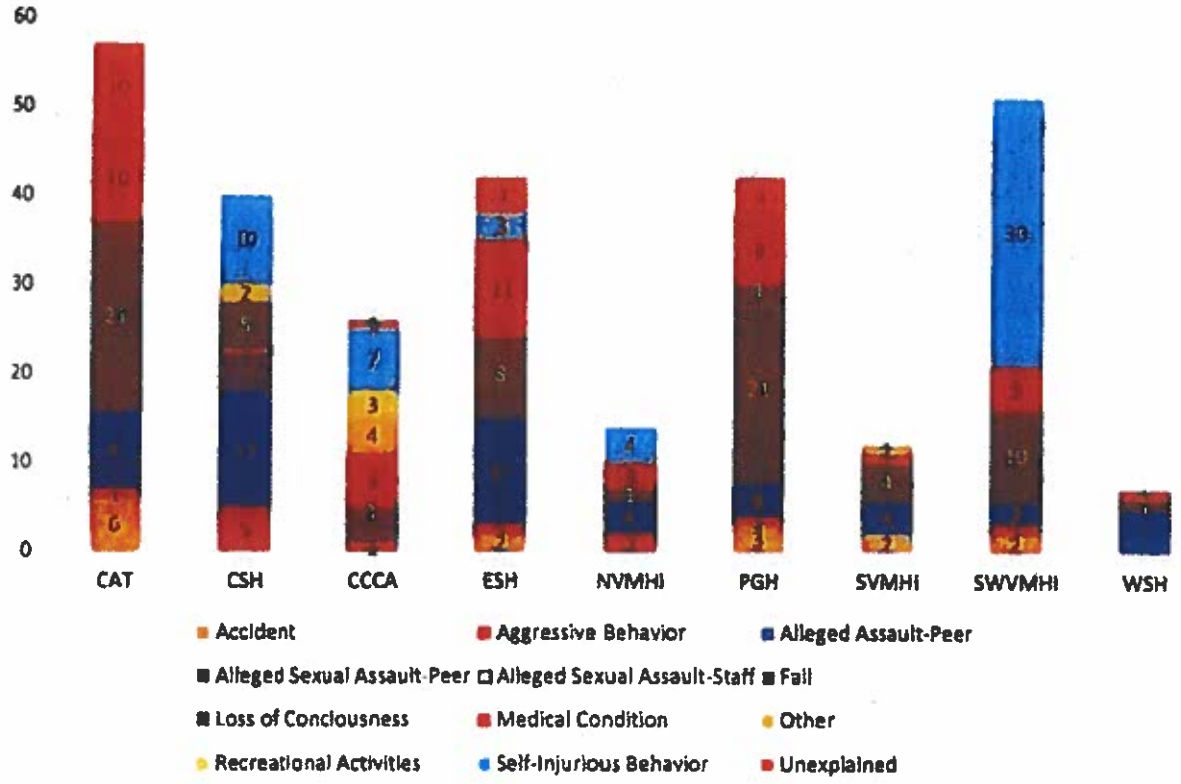
While I understand these variances are supported by Commissioner Smith, until Central State Hospital demonstrates efficiency and effectiveness in their current human rights process, they should not be granted any additional exceptions to the human rights process.

Thank You

Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2018 - September 30, 2019

Prepared by
The disAbility Law Center of Virginia
August 2020

CIR Incident Types at DBHDS-Operated MH Facilities FY 19

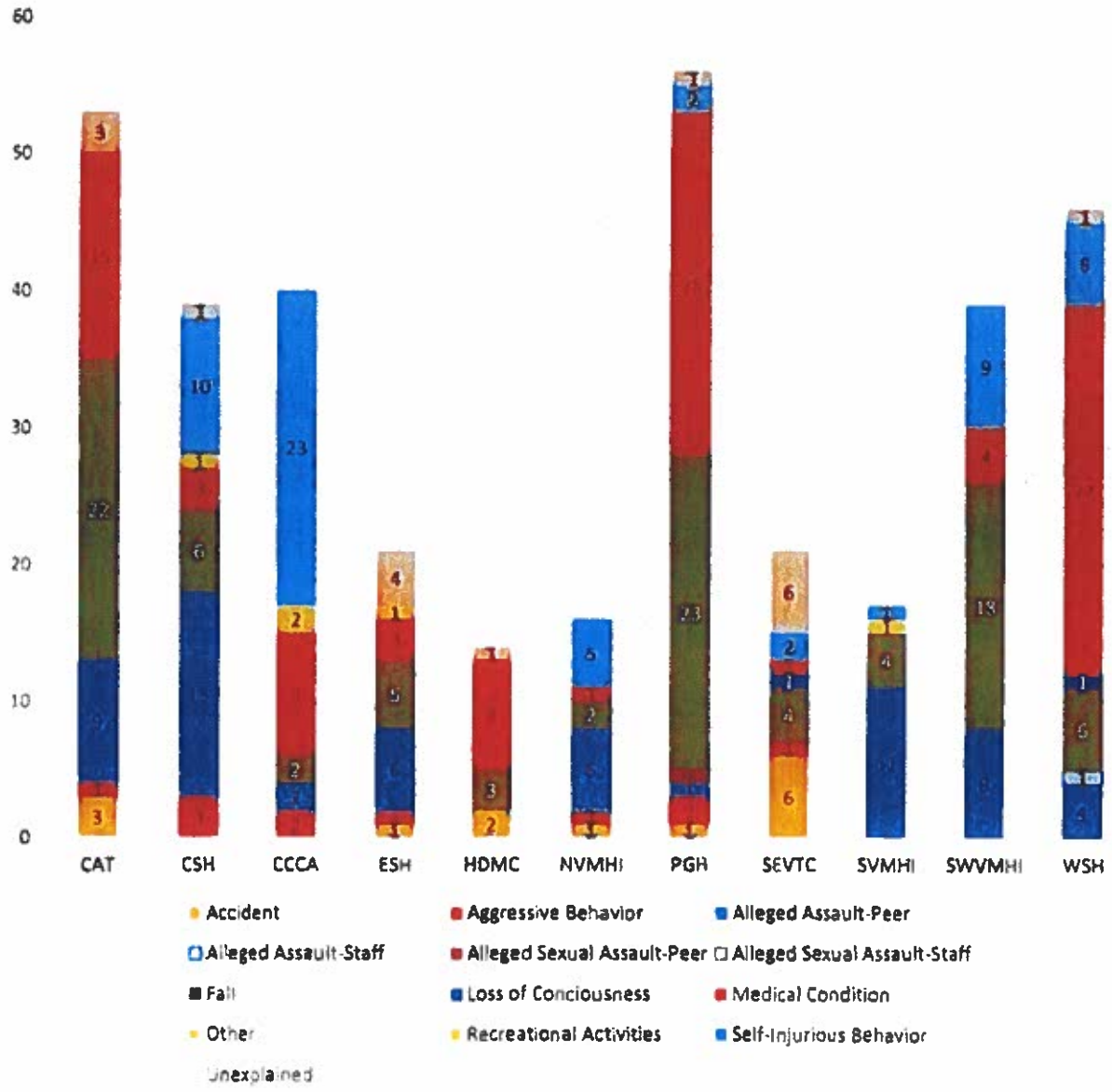


dLCV has long been concerned about Peer-to-Peer Assaults in DBHDS-operated hospitals. CSH and ESH, in particular, have been heavily affected by 2016 legislation requiring that individuals in jails be transferred to State Hospitals for Restoration within 10 days of receipt of a court order. Staff and residents have told dLCV that these psychiatrically-acute individuals have contributed to a rise in Peer-to-Peer violence, as well as self-injury and injuries stemming from other "aggressive behavior." FY 19 CIR data initially appears to supports staffs' assertions that the populations of CSH and ESH continue to be far more prone to peer assault, as evidenced by the fact that they reported the highest number of peer-to-peer assaults (CSH reported 13 and ESH reported 12). However, while the number of peer assaults remains high, it is consistent with the number of peer assaults reported by these facilities last year (CSH reported 12 and ESH reported 13). Moreover, the *per capita* rate of peer-to-peer incidents at CSH and ESH is far less than at other, smaller facilities.

We compared the 4 most prevalent incident types—peer assaults, falls, medical conditions, and self-injurious behaviors (SIB)—across the facilities with the context of population. Below are the *per capita* statistics for FY 18 and FY 19. We exclude CCCA because its uniquely small population and high bed turnover can lead to misinterpretation of the data.

Report on Critical Incidents
In Virginia's State-Operated Facilities
October 1, 2019 - September 30, 2020

Prepared by
The disAbility Law Center of Virginia
April 2021



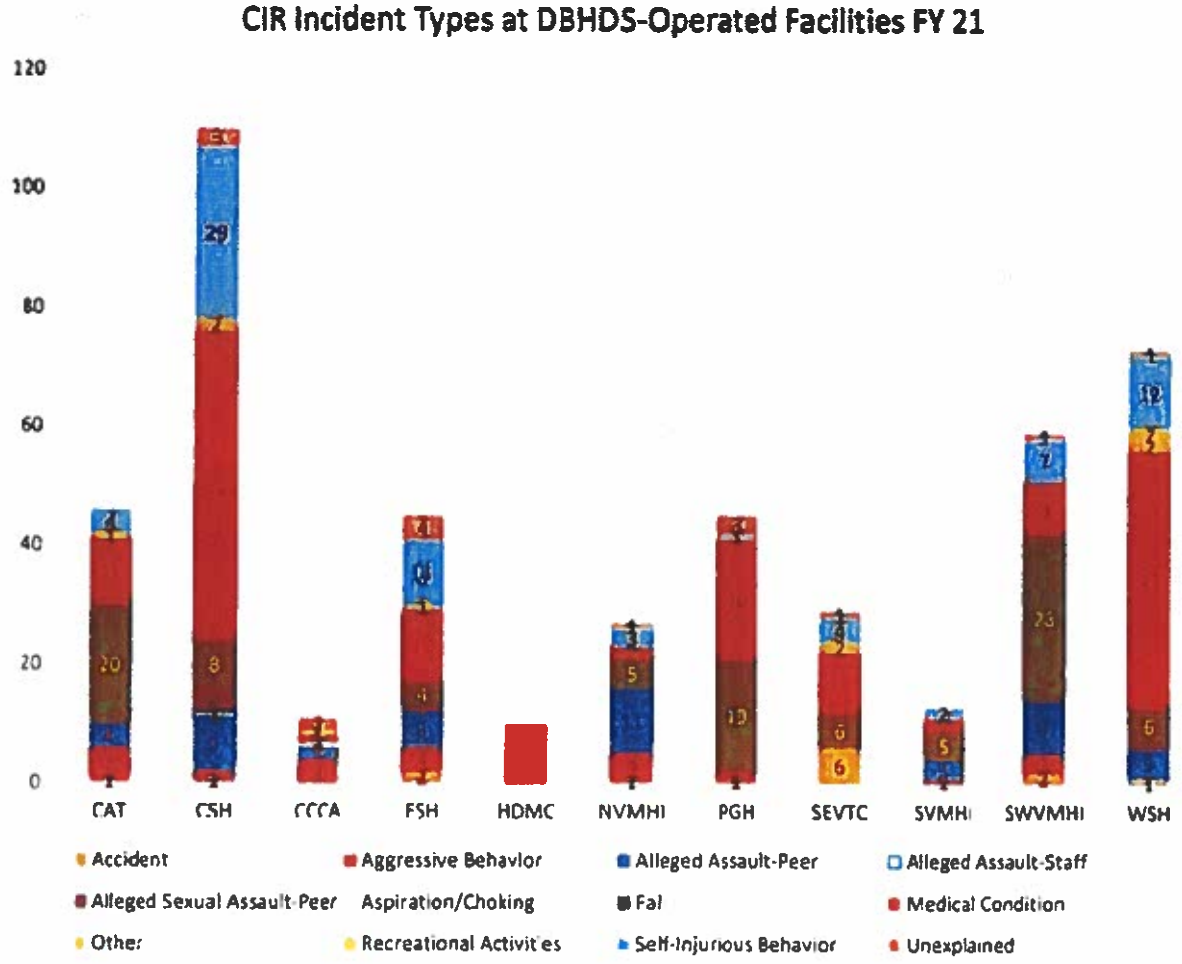
Falls were most common at facilities with geriatric populations, particularly CAT, PGH, and SWVMHI. This is consistent with previous years' data. The distribution of incidents involving medical conditions changed dramatically since FY 19. The above graph shows that WSH reported the most medical conditions (27), followed by PGH (25) and CAT (15). Strangely, ESH, which has geriatric units and has had COVID outbreaks in the last year, reported a decrease in medical conditions, from 11 in FY 19 to 3 in FY 20.

SIB continues to be a problem, but the facilities that reported the greatest amount of SIB shifted during FY 20. During the last two FYs, CSH, CCCA, and SVMHI have reported the greatest number of SIB incidents; while the number of SIBs reported by CSH in FY 20 (10) is consistent with last year (10), CCCA reported substantially more

Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2020 - September 30, 2021

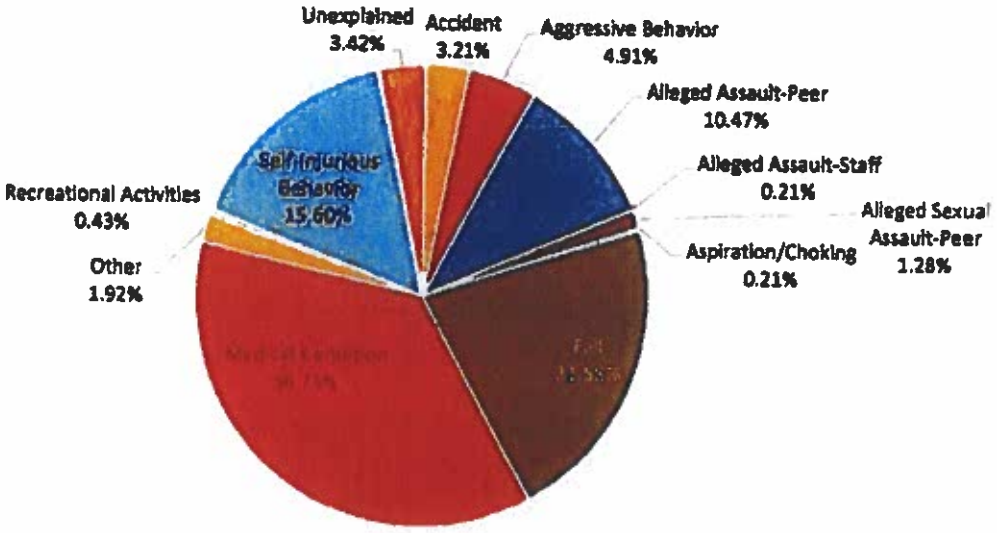
Prepared by
The disAbility Law Center of Virginia
May 2022

Incident Types and Reporting



In FY 21, DBHDS-operated facilities reported 468 Critical Incidents. CSH reported the greatest number of incidents (110), followed by WSH (73). It is important to note that WSH has improved with regard to the frequency of their reporting. At first glance, it appears the number of CIRs at CSH is extremely high. However, nearly half of the CIRs reported by CSH (52) and over half of the CIRs reported by WSH (43) were medical conditions that the hospital reported voluntarily, but may not have been strictly required under state law. While medical conditions do not always have to be reported under Virginia Code, it is immensely helpful to have this logged somewhere. State Hospitals, unlike licensed community providers, do not report unexpected illnesses to DBHDS. This can result in less accountability. By voluntarily reporting medical and other incidents, State Hospitals add a level of transparency to their practices and better contextualize their services.

Proportion of CIR Incident Types at All DBHDS-Operated Facilities FY 21



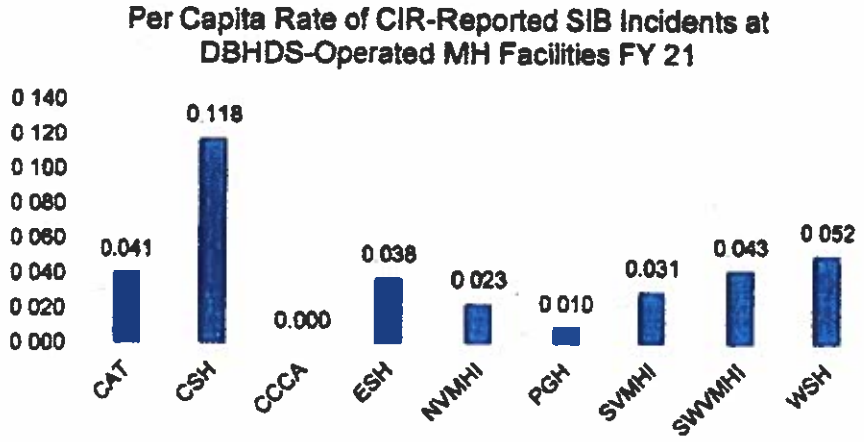
There was a significant increase in medical conditions reported across all DBHDS facilities, though, as we stated previously, some of these were voluntarily reported. In FY 21, medical conditions accounted for 36.75% of all incidents reported. For comparison, in FY 20 medical conditions accounted for only 26.52% of all incidents reported. Falls were the second most prolific incident type reported across all DBHDS facilities, accounting for 21.58% of all incidents reported. Although this number remains high, it has continued its downward trend since dLCV has been publishing CIR reports. Self-Injurious Behavior is the third most common incident type, accounting for 15.6% of all incidents reported.

Self-Injurious Behavior

Self-Injurious Behavior (SIB) may have made up only 15.6% of incidents in FY 21, but it is an acute category that deserves further scrutiny.

SIB was most common at large facilities with many court-involved residents. CSH reported the highest rate of SIB, with 29 instances, which made up 26.6% of all their FY 21 critical incidents. ESH reported 11 incidents of SIB, which made up 24.44% of their reports. WSH reported 12 instances of SIB, making up 16.44% of their reports.

When adjusted for population, we can see that the per capita rate of self-injurious behaviors is still exceptionally high at CSH (0.118 incidents *per capita*), but does not appear as prolific at ESH (0.038 incidents *per capita*) or WSH (0.052 incidents *per capita*).



While looking at the data is important to examining SIB at DBHDS-operated facilities, nuance and context are also important. At CSH in particular, it appears that the rate of SIB was largely driven by a small number of acute residents with multiple SIB episodes. It is also worth noting that CCCA, which usually reports a high number of SIB episodes, reported no instances of SIB in FY 21. It is unclear if this is due to an actual decrease in incidents or simply due to poor reporting practices, which we have cited in previous public reports.

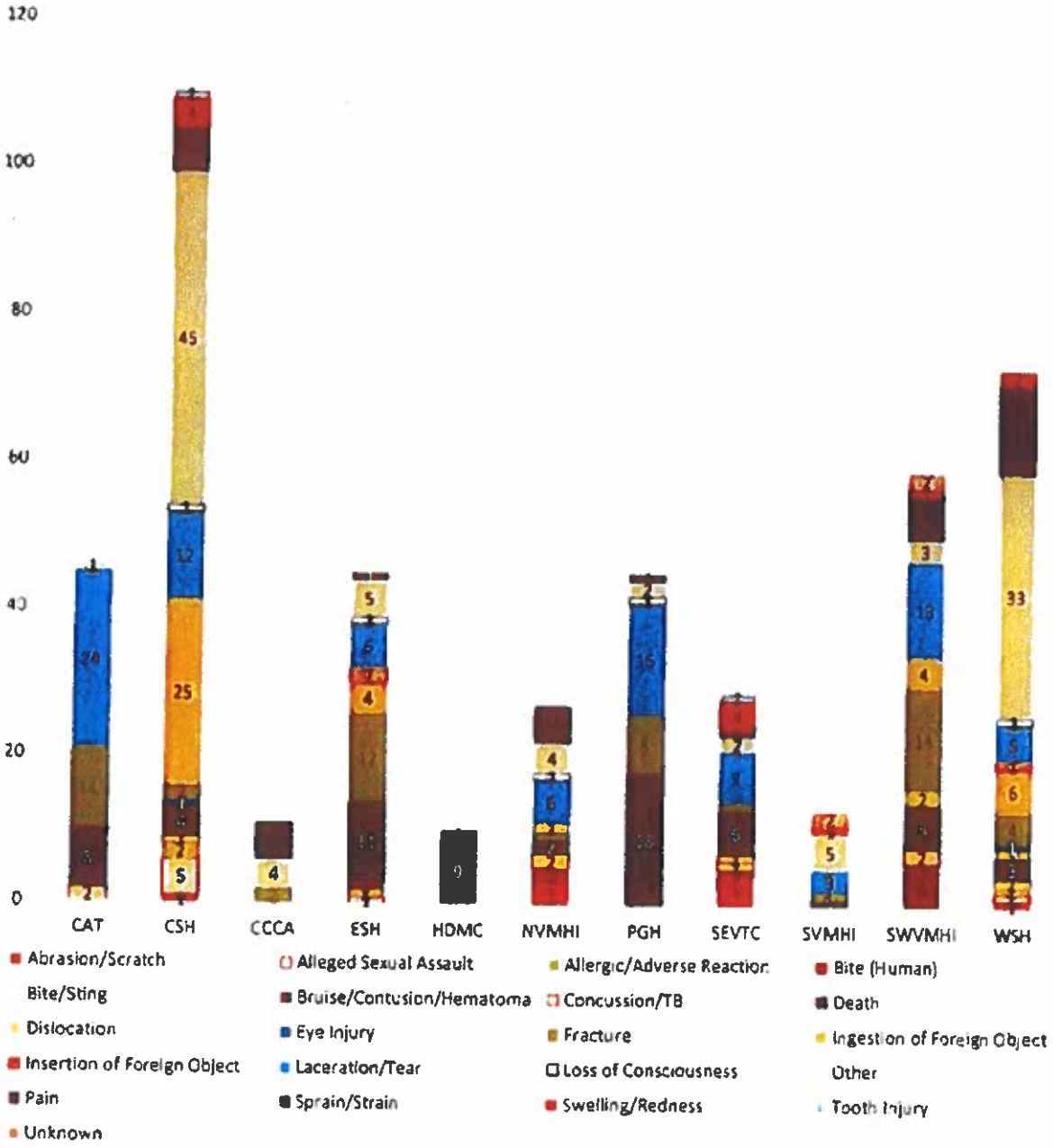
State Hospitals are currently allocating substantial resources to preventing SIB, in the form of increased staffing ratios for at-risk patients and environmental precautions. While the facilities should absolutely be taking steps to prevent SIB, dLCV wonders if their efforts might be at least partially misplaced.

The vast majority of individuals who engage in SIB as part of their clinical presentation have long histories of trauma. The link between trauma—particularly in childhood or young adulthood—and self-harm is well-documented. DBHDS has long given lip-service to the concept of Trauma Informed Care[1], training staff, and including the language and general principles of Trauma Informed Care in their daily practice. That said, dLCV has heard from countless residents that they rarely, if ever, receive individual therapies, that trauma-informed treatment modalities (such as Dialectical Behavioral Therapy) are not widely available, and that trauma triggers are often not documented, or are ignored during behavioral crises. Providing patients with meaningful Trauma Informed Care at a clinical level, specifically dialectical behavior therapy, would be essential in addressing high rates of SIB across DBHDS facilities.

[1] Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Injury Types and Reporting

CIR Primary Injury Types at DBHDS-Operated Facilities FY 21



dLCV also monitors the types of injuries reported at all DBHDS facilities every year. Due to the increase in reporting of medical conditions during FY 21, the injury category labeled "other[2]" is unusually high. The "other"

[2] The Category "Other" is used to describe incidents in which an individual was impacted with physical symptoms or a diagnosis that does not fit into any other defined category. As categories were developed to generally describe injury

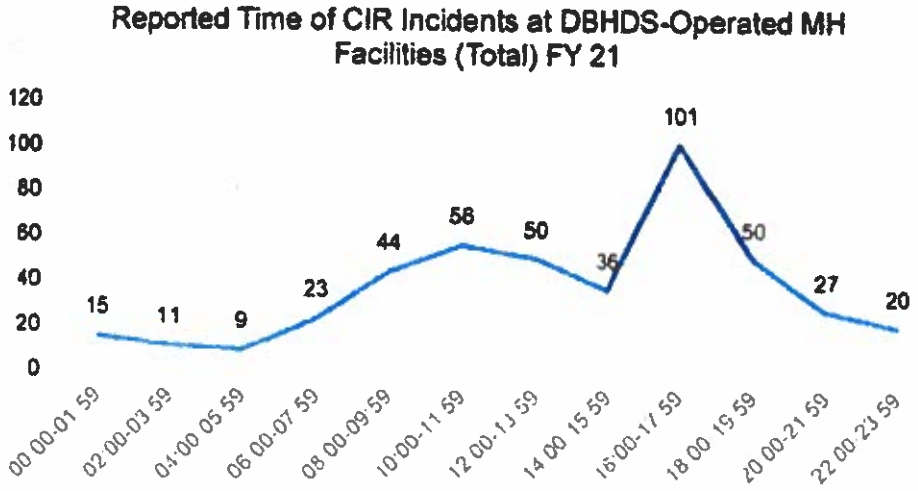
category made up the largest proportion of CIR injury types at all DBHDS facilities, accounting for 104 instances, or 22.22% of all injury types.

Laceration/Tears made up the second-highest proportion of CIR injury types reported, accounting for 94 instances, or 19.44% of injury types reported. Laceration/Tear was most common at CAT, which reported 24 instances in this category.

Deaths made up the third-highest proportion of CIR injury types reported, accounting for 66 instances, or 14.53% of injuries reported. We will explore Deaths in greater detail beginning on page 9.

While only 40 instances of "Ingestion of Foreign Object" were reported in FY 21, the overwhelming majority of these (25) occurred at CSH and are tied to that facility's unusually high rate of SIB.

Incident Timing



dLCV observed a disproportionate number of Critical Incidents occurring between 4-6pm. Upon closer inspection, it appears this trend is being driven almost exclusively by CSH, which also reported an unusually high number of incidents occurring on Wednesdays. More information is needed to understand why there is such a significant increase in incidents at that time. Possible factors include staff shortages and lack of structured programming.

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instead of illness, the majority of "medical conditions" that do not result in death can only be described using the "other" category.

Continuing Education Article

Nonsuicidal Self-Injury: Management on the Inpatient Psychiatric Unit

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Laurie M. Timberlake[1], Linda S. Beeber[2], and Grace Hubbard[3]

Abstract

BACKGROUND. Between 4% to 70% of inpatients engage in self-harming behaviors and effective interventions are needed to address this population. **AIM.** This article reviews literature from 2007 to 2017 to address treatment and management strategies specific for the treatment of nonsuicidal self-injury in the inpatient psychiatric setting. **METHODS.** Cochrane, PsycINFO, PubMed, and CINAHL were searched for relevant articles with 34 studies reviewed for applicability to the question, and 9 parsed into a summary of Findings table. **RESULTS.** Therapeutic approaches that show promise include cognitive behavioral therapy, dialectical behavior therapy, and mentalization as well as medications that act on the serotonergic, dopaminergic, and opioid systems. Effective models of care aim toward enhancing therapeutic relationships with staff, providers, and most important, encouraging the internal shift toward recovery within the patient. **CONCLUSIONS.** More research with controlled designs in the inpatient setting is needed, however, regardless of which approach is used, the impact of the individual caregiver on the patient's recovery is key.

Keywords

nonsuicidal self-injury, inpatient, management, treatment

Nonsuicidal self-injury (NSSI) is defined by the International Society for the Study of Self-Injury (ISSS, 2007) as "deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned." Known by various names, including deliberate self-harm, self-injurious behavior, and self-mutilation, NSSI is practiced in the United States between 4% and 5.9% of the general public (Briere & Gil, 1998; Klonsky, 2011), 19% of those younger than 30 years (Klonsky, 2011), and internationally, by as many as one in five adolescents (Muehlenkamp, Claes, Havertape, & Plener, 2012). The most common forms of NSSI are cutting, head-banging, punching/kicking, and suffocation/strangulation, but other forms may include interfering with wound healing, burning, and self-poisoning, as well as less common acts such as electrocution, biting, and binging (James, Stewart, & Bowers, 2012). NSSI is distinct from self-harm inflicted in a psychotic state or with suicidal intent (Angelotta, 2015), although a patient may be both suicidal and engage in NSSI (Asarnow, Porta, & Spirito, 2011) or progress from NSSI to suicidality (Asarnow et al., 2011; Glenn & Klonsky, 2013). Between 4% (Bowers, Simpson, & Alexander, 2003) to 70% (Swinton, Hopkins, & Swinton, 1998) of inpatients engage in NSSI. Despite this prevalence, there is no evidence that our current inpatient treatments are preventing future suicides among those who practice NSSI (Crawford, Thomas, Khan, & Kulinskaya, 2007; James et al., 2012).

The standard treatment for self-injury in the inpatient unit often calls for one-on-one staffing/constant observation, PRN medications, and removing all "sharps" from the environment. These current policies are often counterproductive (James et al., 2012), both for the individual patient and the larger milieu. Placing patients who have used NSSI on close observation or one-to-one with nursing staff—a common inpatient response to self-harming—may be interpreted as punitive, while introducing concerns related to privacy loss, loss of therapeutic alliance, secondary gain, and ironically reduced engagement on the part of the staff (Slemon,

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Jenkins, & Bungay, 2017). Some studies have shown that constant observation has either no effect, or actually leads to increased rates of self-harming (Bowers et al., 2008; Stewart, Bowers, & Warburton, 2009). Removal of sharps and attempting to limit dangerous items available in the inpatient environment become a challenge that is often impractical, may backfire or be easily circumnavigated by the determined patient (James et al., 2012) with no clear alternatives available to maintaining unit safety. In addition, unstructured free time with peers and minimally supervised use of the internet in common areas conspire to distance patients therapeutically from nursing staff, while maximizing opportunities for social contagion (Brown et al., 2018; Jarvi, Jackson, Swenson, & Crawford, 2013).

Clarity on appropriate treatment and management of NSSI continues to be a challenge (Hetrick, Robinson, Spittal, & Carver, 2016; Turner, Austin, & Chapman, 2014). This is especially true in the inpatient setting, where most interventions are geared toward suicidality or borderline personality disorder (BPD; Klonsky, Victor, & Saffer, 2014). Furthermore, NSSI and suicidality overlap (Asarnow et al., 2011; Guan, Fox, & Prinstein, 2012; Owens, Horrocks, & House, 2002), with suicidal risk increasing over time (Greydanus & Apple, 2011). NSSI has been shown to be a significant prospective predictor for future suicide attempts, more so than past suicide attempts (Glenn & Klonsky, 2013; Guan et al., 2012). Reasons for this progression may include habituation to self-harm or shared risk factors between NSSI and suicidality (Asarnow et al., 2011). Effective intervention is key to prevent escalation of harm, especially given concerns for social contagion and milieu management within psychiatric inpatient units (James et al., 2012). The purpose of this article is to review the latest research on treatment and management of NSSI specific for the acute inpatient psychiatric population.

Method

Cochrane, PsycINFO, PubMed, and CINAHL were searched for peer-reviewed articles from the past 10 years (from 2007 to 2017). Search strings were developed with the assistance of a librarian to capture articles specific to NSSI in the inpatient psychiatric setting (Table 1). Inclusionary criteria included studies that primarily focused on the adolescent, young adult, and adult populations in the inpatient psychiatric setting; studies that either explicitly focused on NSSI or distinguished within the study between NSSI and other self-harming behaviors, including suicidal acts. Exclusionary criteria included the following: developmentally delayed populations, psychotic disorders, TBI (traumatic brain injury) populations, abstract only/poster presentations, studies that did not distinguish between suicidal and NSSI, and studies that focused exclusively on child and geriatric populations. While it is recognized that the adolescent and adult populations are quite different, the focus of this article is management in the inpatient setting and the unique challenges that presents.

Results

While *NSSI* is the correct term for the area of interest, less-specific terms such as *self-harm* were included to cast a wider net for relevant articles (Table 1). A total of 428 articles were imported with 86 duplicates removed. A total of 342 articles were screened by two independent reviewers for inclusion. The guiding question for inclusion was "Does this article help answer the question of how to manage NSSI in the inpatient psychiatric setting?" While the goal had been to find high caliber research studies with controlled variables to point toward best practices, there is very little research specific to both NSSI and the inpatient psychiatric setting. Because of this, studies that did not meet the criteria of randomized control trials were included when findings could clearly be extrapolated to the inpatient setting. Ultimately, 50 studies were read in full, with 14 studies then excluded for reasons delineated elsewhere, leaving 36 studies to be parsed for applicability to the question (Figure 1). Of these, five were retrospective trends analyses and five were interview based, either hermeneutic phenomenological or grounded theory–driven research. The remaining articles included models of care that have been used with varying success in hospital settings, unit-based strategies, medication trials, and nursing interventions. Also included are four systematic reviews focused on self-injury. The authors followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberti, Tetzlaff, Altman, & the PRISMA Group, 2009) guidelines in determining study selection, characteristics, risk of bias, and outcomes. Nine studies meeting more tangible applicability to the original inpatient unit-focused question were further parsed into a summary table (Table 2), although the full 36 articles are included in the discussion that follows.

Findings

There are few articles that focus on NSSI within the inpatient population, and of those that do, very few are empirical in nature (Nixon & Heath, 2009). The paucity of empirical research for the adolescent setting, where these behaviors are most prevalent, is more remarkable (Lofthouse & Katz, 2009; Washburn, Richardt, et al., 2012). The authors hope that in combining the scant

Table 1. Search Strategies.

Database	Search String	Limiters	Articles
PsycINFO	(DE "Self-Mutilation" OR DE "Self-Inflicted Wounds" OR DE "Self-Injurious Behavior" OR DE "Self-Destructive Behavior" OR "NSSI" OR TI("self-injury" OR "self-harm" OR "self-injurious" OR "self-injure" OR "self-inflict" OR "self-inflicted" OR selfinflict* OR "self-mutilate" OR "self-mutilating" OR "self-mutilation" OR "self-destructive" OR "NSSI" OR "non-suicidal") OR AB("self-injury" OR "self-harm" OR "self-injurious" OR "self-injure" OR "self-inflict" OR "self-inflicted" OR selfinflict* OR "self-mutilate" OR "self-mutilating" OR "self-mutilation" OR "self-destructive")) AND ((DE "Management") OR (DE "Prevention") OR (DE "Intervention") OR (DE "Best Practices") OR TI(manag* OR minim* OR interven* OR strateg* OR prevent*) OR AB(manag* OR minim* OR interven* OR strateg* OR prevent*)) AND (inpatient* OR hospitaliz*) AND psychiatr*	2007-2017; peer reviewed; English; ages 13-64 years	133
PubMed	((((((((((("Self-Injurious Behavior"[Mesh] OR "self-injury"[title/abstract] OR "self-harm"[title/abstract] OR "self-injurious"[title/abstract] OR "self-injure"[title/abstract] OR "self-inflict"[title/abstract] OR "self-inflicted"[title/abstract] OR selfinflict* OR "self-mutilate"[title/abstract] OR "self-mutilating"[title/abstract] OR "self-mutilation"[title/abstract] OR "self-destructive"[title/abstract]) AND (manag*[title/abstract] OR minim*[title/abstract] OR interven*[title/abstract] OR strateg*[title/abstract] OR prevent*[title/abstract] OR treat*[title/abstract]) AND (inpatient* OR hospitaliz*) NOT suicide[Mesh] NOT surger*) AND "last 10 years"[PDat] AND English[lang])) NOT (psychotic[Title/Abstract] OR psychosis[Title/Abstract] OR schizophrenia[title/abstract] OR surgery[Title/Abstract] OR surgical[Title/Abstract])) AND "last 10 years"[PDat] AND English[lang])) AND psychiatr*[Title/Abstract])) AND "last 10 years"[PDat] AND English[lang])) AND "last 10 years"[PDat] AND English[lang]) Filters: published in the last 10 years; English	2007-2017; English; ages 13-64 years	127
Cochrane reviews	((NSSI OR self-injur* OR self-harm OR self-inflict*) AND non-suicidal) AND psychiatr* AND (inpatient OR ward OR unit) AND (management OR treatment)	2007-2017	7
CINAHL	(SU(Self-Injur* OR NSSI OR self-harm) AND AB(inpatient OR in-patient OR ward OR unit) AND AB(treat* OR manag* OR prevent* OR interven*) AND TX(psychiatr*)) NOT surger	2007-2017; ages 13-64 years	138

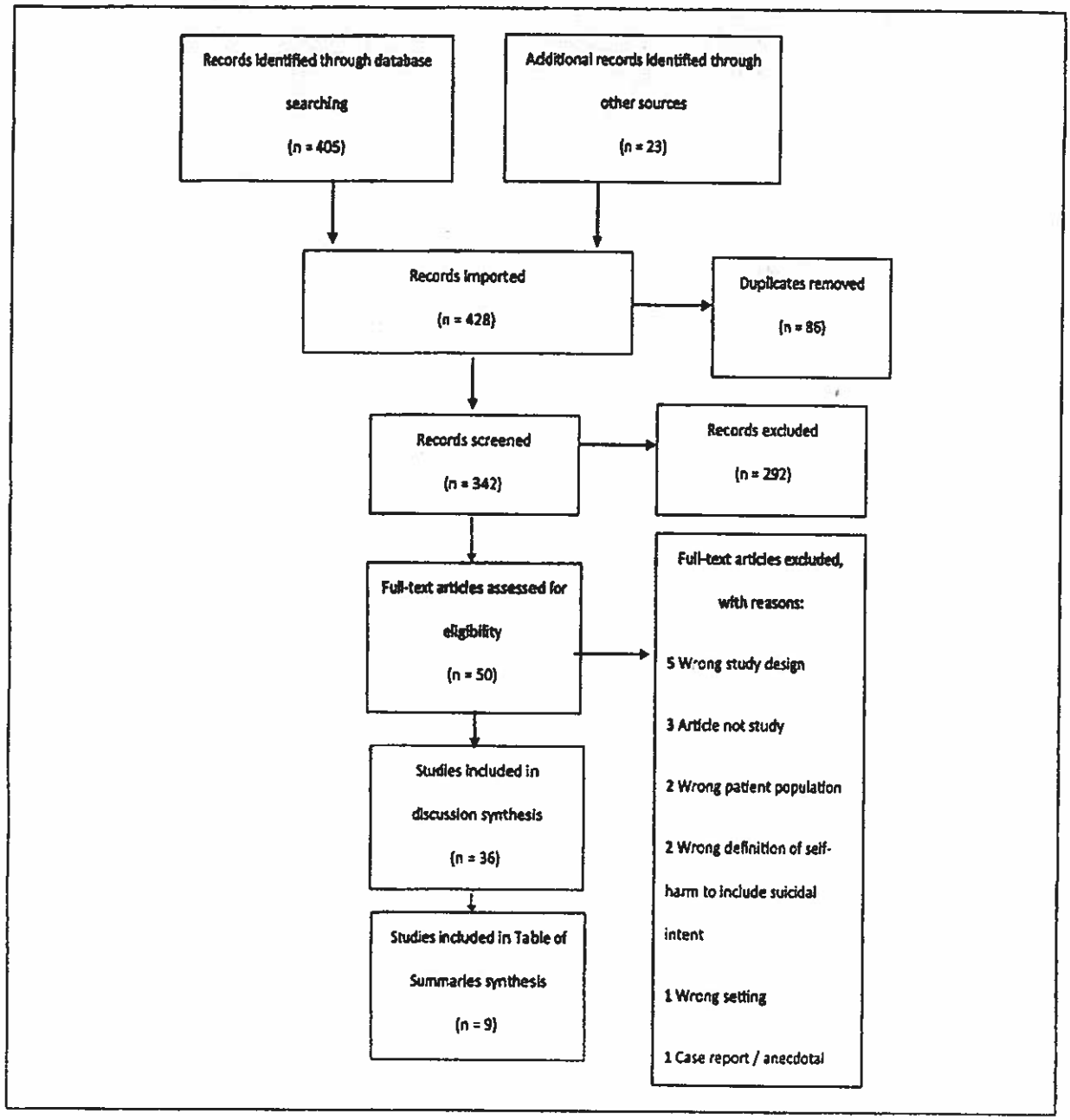

Figure 1. PRISMA chart.
Note. PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses. Flowchart adapted from Moher, Liberti, Tetzlaff, Altman, and the PRISMA Group (2009).

research for managing NSSI in both populations, adult and adolescent, a cohesive approach will emerge that may be tailored to meet specific unit needs. While the available research is critical to understanding the context within which self-injury occurs, the mitigating and protective factors as well as prospective approaches to the management and treatment of self-injury, it does little to handle the emergent needs of the inpatient staff treating a self-injuring patient or the psychiatric mental health nurse practitioner (PMHNP) guiding that team. Still, these articles offer insights that can inform future research and provide guidance in the here and now.

Table 2. Summary of Findings.

Author/Year	Design	Purpose	Subjects	Scales	Findings	Risk of Bias	Key Points
Bowers et al. (2015)	Pragmatic cluster RCT	To test the efficacy of 10 interventions implemented across wards	Staff and adult patients in 31 wards at 15 randomly chosen hospitals	PCC Self-harm Antipathy Scale APDQ Ward Atmosphere Scale SF-36v2, a short form healthy survey	Decreased rate of conflict events by 15% Decreased rate of containment by 26.4% No secondary outcome change except improved health for control group	Contamination/performance bias—79% managers/staff discussed interventions with opposing branch of study	10 Safewards interventions as detailed online at www.safewards.net would be feasible to implement in practice with indications of significant possible reductions in adverse events.
Ercole-Fricke, Fritz, Hill, and Snelders (2016)	Quantitative comparative quasi-experimental design; retrospective surveys, EMR.	To achieve a cultural transformation and altered routine responses using CPS model	Staff and patients in one inpatient adolescent unit over 5 years	Staff surveys	"Decrease in punitive practices led to significant decrease in aberrant behavior." Significant decrease in punitive strategies and techniques, decreased behaviors leading to need for restraints; significant decline in NSSI	No control group, use of surveys suggests concern for self-report bias	CPS on the unit between patients and staff led to whole culture shift.
Gibson, Booth, Davenport, Keogh, and Owens (2014)	Controlled trial, single-centered nonrandomized clinical trial	To "examine whether the addition of the DBT-informed skills training program, LTD, was associated with improved outcomes for self-harming patients"	$N = 103$ adult patients	DSHI Depression and Anxiety subscales of the SCL-90-R DERS CERQ-short SCID-II	Decreased frequency of self-harm with 49% of patients showing reduction of 75% or greater among the LTD + TAU group. 19% show no or increased self-harm. Emotion regulation changes positively correlate between DSH and inability to engage in goal-directed behavior. Negative correlation between DSH and planning was statistically significant.	Nonrandomized, cannot determine that there are no systematic differences between groups	Sustained self-harming reduction noted at 3 months follow-up. Reductions in self-harm were associated with improvements in Planning score as measured by CERQ. DBT-informed skills group without other components of DBT may be clinically useful in inpatient setting. LTD + TAU associated with greater reduction in self-harm behavior than TAU in inpatient setting and reductions maintained at 3 months follow-up. Putting in perspective and planning led to improvements in emotion regulation.
James, Stewart, and Bowers (2017)	Surveys and semistructured qualitative interviews with intensity subsampling	To measure attitudes of mental health staff toward harm reduction for self-harming inpatients	$N = 393$ nurses over 31 wards then 18 interviews	SHAS	Many staff agree with harm reduction in principle—most are reluctant to implement it in practice. Insights into perspectives.	Concern for lack of generalizability both to outpatient providers and staff with prior experience with harm reduction	Views on harm reduction linked to participants' beliefs about self-harm. Lack of proper preparation phase can lead to concerning inconsistencies and increased staff stress.
Karman, Kool, Gamel, and van Meijel (2015)	Grounded theory, semistructured interviews with systematic data analysis—qualitative study	To investigate professional behavior of MD nurses with positively changed attitudes after a training program	$N = 11$ mental health nurses	ADSHQ	7 out of 10 behavior changes had positive influence on relationships with patients. 9 out of 10 report increased understanding of patient's understanding. 4 out of 10 increased focus on normal/healthy aspects of patient's functioning.	Broader sample needed, lack of empirical support for model, overt selection bias in choice of subjects	Follow-up to 2014 Kool study on the training program devised to increase empathy and improve attitudes among 360 professionals caring for patients who self-harm.

(continued)

Table 2. (continued)

Author/Year	Design	Purpose	Subjects	Scales	Findings	Risk of Bias	Key Points
Kool, van Meijel, Koeldoek, van der Bijl, and Kerkhof (2014)	Quasi-experimental pre-/posttest design to measure effectiveness of training program, analyzed descriptively	To train health care workers in how to effectively communicate with patients who self-harm, using lay experts and an art program.	*N* = 178 nurses and social workers between eight mental health centers and one forensic psych facility	ATDSHQ SEDSHQ PCQ	Significant increase in total scores of all 3 questionnaires; more positive attitude, improved self-efficacy, and greater closeness w patients were found after training with stability of results at week.	Concern for attrition/ response bias as 51% subjects did not complete questionnaire and use of self-report questionnaires. Lack of control group. Reliability questionable given internal consistency concerns.	Study does not show affect on patients, but calls for increased efforts to train staff with expectation that improving staff understanding and attitudes will lead to better care and improved outcomes for patients.
Livesey (2009)	Retrospective data analysis	To demonstrate effects of a no-tolerance policy on levels of self-harm in an inpatient adolescent setting	One 13 bed adolescent inpatient unit with additional 12 day-patient spots	Incident reporting before and after change in policy	After initial testing period when first implemented, levels dropped to near zero. Initial self-harm leads to suspension, meeting with patient and family to renegotiate involvement with program, with understanding second self-harming act leads to expulsion. No patient has been expelled since program implementation	No control group; no pre- to postintervention assessments done.	Approach not only depends on staff being willing to enforce suspension and possible expulsion from program if self-harming occurs but also offers significant alternative strategies, treatments, and attention to avoid this. Policy considers self-harm as equivalent to violence against another.
Ray, Perkins, Roberts, and Fuller (2017)	Descriptive retrospective analysis of different observation levels	To identify the impact PNA and PMI levels of observation had on the number and duration of patients under CSO.	*N* = 426 adult patients in a 17 bed inpatient adult unit	15-minute check sheets showing observation levels	PNA indicated for SI and NSSI, limiting its scope, and led to no noticeable change in CSO. PMI led to reduced use of CSO. PMI use increased staff visibility and engagement for all patients. PMI has protective effect on milieu	Concern for lack of generalizability/external validity, lack of control group, lack of pre- to postintervention measurements	Interventions based on engagement and nurse driven, not one size fits all. CSO is cost-intensive and intrusive to patients. Authors suggest increased visibility and engagement are seen as signs of staff caring and offers them hope. This can be achieved without being protocol driven.
Thomassin, Guérin Marion, Venasse, and Shaffer (2017)	Descriptive analysis, cross-sectional design	To examine the moderating effect of five coping strategies on the relationship between NSSI and emotion regulation	*N* = 95 adolescent patients	DSHI Emotion Expression Scale for Children children's coping strategies checklist Youth Self-Report (psychopathology symptom questionnaire)	Positive reframing and support seeking are significant moderators of poor emotion expression to NSSI link. Problem focused coping, distraction, and avoidance do not emerge as significant moderators. No gender differences noted.	Moderate sample size, no second reviewer for assessment of subject's, psychiatric history/file review, study conducted prior to NSSI *DSM-5* (American Psychiatric Association, 2013) criteria, using nonspecific self-harming criteria	Provides support for assisting adolescents with emotion expression skills and encouraging use of positive reframing and support seeking

Note. APDQ = Attitude to Personality Disorder Questionnaire; ATDSHQ = Attitudes Towards Deliberate Self-Harm Questionnaire; CERQ-Short = Cognitive Emotion Regulation Questionnaire–Short Form; CPS = collaborative problem solving; CSO = constant special observation; DBT = dialectical behavior therapy; DERS = Difficulties in Emotion Regulation Scale; DSH = deliberate self-harm; DSHI = Deliberate Self-Harm Inventory; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition; EMR = electronic medical record; LTD = living through distress; NSSI = nonsuicidal self-injury; PCC = Patient-Staff Conflict Checklist; PCQ = Patient Contact Questionnaire; PMI = Psychiatric Monitoring & Intervention; RCT = randomized control trial; SCID-II = Structured Clinical Interview for *DSM-IV* Axis II Personality Disorders; SCL-90-R = Symptom Checklist-90-Revised; SEDSHQ = Self-Efficacy in Dealing with Self-Harm Questionnaire; SHAS = Self-Harm Antipathy Scale; TAU = treatment as usual.

Assessment Tools

Assessment should be done on admission to the inpatient unit to determine the presence and severity of NSSI, as well as the function NSSI serves, using tools that are evidence-based (Stewart et al., 2012) and typically administered within the context of the clinical interview. Quinlivan et al. (2017) asserted that no current measurement tool proves useful for this task, while others have advocated the use of the Inventory of Statements About Self-Injury (ISAS), stating it has good test–retest reliability, as well as construct validity (Glenn & Klonsky, 2011; Klonsky, Muehlenkamp, Lewis, & Walsh, 2011). Latimer, Meade, and Tennant (2013), however, stated the ISAS is more appropriate for a broader interpretation of self-harm, which does not address lethality of method or intent of harm. In their study comparing several commonly used self-harm scales, they advocated for the use of three scales to measure NSSI—the Deliberate Self-Harm Inventory (Gratz, 2001), The Self-Injurious Thoughts and Behaviors Interview (Nock, Holmberg, Photos, & Michel, 2007) and Self-Injury Questionnaire Treatment Related (Claes et al., 2010)—all of which have good psychometric properties. Latimer et al. (2013) used the Rasch measurement model (Rasch, 1960), which provides for strict post hoc testing of unidimensionality, and additionally reported they were given evidence by the scale developers of reliability and external validity.

A fourth scale, not addressed in the 2013 study by Latimer et al., is the Ottawa Self-Injury Inventory (OSI; Nixon & Cloutier, 2005), which addresses the addictive features of the individual's self-injury and was shown to be both valid and reliable with excellent internal consistency (Martin et al., 2013; Nixon, Levesque, Preyde, Vanderkooy, & Cloutier, 2015). The OSI includes seven questions modified from the substance dependence criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (*DSM-IV-TR*); one example given in Nixon et al. (2015) is "Despite a desire to cut down or control this behavior, you are unable to do so." Given the more recent links being studied between self-injurious behavior and the opioid receptors, as reviewed in the Medication Intervention section, this scale seems especially valuable (Stanley et al., 2010).

These scales measure the patient's past and present NSSI—and in that sense they offer some predictive information as well. Glenn and Klonsky (2011) found that the only variables that reliably predict future NSSI were past NSSI, the patient's own predictions of their future NSSI behaviors, and the presence of BPD features. The authors suggested that BPD traits may be linked to a poor prognosis for those who self-injure, regardless of a BPD diagnosis, and call for future research to duplicate their results. The variety of methods used to deliberately self-harm is also prospectively predictive of future NSSI (Glenn & Klonsky, 2011) and, taken with data on frequency of NSSI and presence of hopelessness, is linked to higher risks of future suicide (Victor & Klonsky, 2014).

Inpatient Admission Interventions

Once the severity and purpose of their self-injury is established, interventions should address that underlying need and not focus solely on the prevention of NSSI behaviors (Klonsky, Glenn, Styer, Olino, & Washburn, 2015; Thomas & Haslam, 2017). Alternative distress management strategies must be taught or provided, such as meditation skills, medications, or distractions, and individualized care plans are indicated, which provide the specific support that the patient most needs (Thomas & Haslam, 2017). O'Donovan (2007) reported that the patient's person and belongings are typically searched on arrival, the patient is placed in their nightclothes, and their rooms secured with objects removed that are deemed unsafe. Exactly what is removed may depend on the level of risk, but often includes scissors and razors, and some staff reported removing pencils, combs, nail clippers, shoe laces, and other items (O'Donovan, 2007). Books and magazines are typically searched for contraband razors or other sharps hidden within and staples in magazines or papers are removed. Typically, spiral bound notebooks and journals are not allowed in the inpatient setting. While these restrictions appear as commonsense harm prevention approaches, there is little empirical support for them in the literature.

Staffing/Therapist Availability and Adverse Events

Berntsen et al. (2011) noted evidence that a full complement of competent, engaged staff, supportive leadership styles, and comprehensive training on the use of physical restraints, lead to markedly decreased incidents of self-injury, seclusion, and aggression. One imagines that increased visibility of staff, as suggested by Ray, Perkins, Roberts, and Fuller (2017), and the decreased staff anxiety that improved restraint training and good leadership brings, may lead to a tangibly less-stressed atmosphere on the unit, and with that, less likelihood of self- or other-directed violence. This finding aligns nicely with evidence provided by Bowers, Allan, Simpson, Nijman, and Warren (2007) who noted that adverse events on the unit, such as aggression, self-harm, or absconding, are most likely following earlier adverse events or occur during times when regular staff are absent—either for vacation, sick, maternity leave, or due to position vacancies. This is also true when there have been multiple new male patient admissions to the unit (Bowers et al., 2007).

Regardless of gender, among adult patients, 1 out of 10 patients will likely self-harm, and often within a short time of admission to the unit (Stewart, Ross, Watson, James, & Bowers, 2012). This research stated an assessment of risk should be done soon after arrival to the unit and offered the following warning signs for imminent self-harm: substance withdrawal, noncompliance with medications or procedures, and expressed desire to leave the unit (Stewart et al., 2012).

Similarly, adolescents with four or more psychosocial stressors or known familial trauma are highly likely to engage in repeated self-harm or aggression on the inpatient unit, especially when undergoing a change in therapist or when their usual therapist is not available (Ulke, Klein, & von Klitzing, 2014). This may be because of staffing turn-over, therapist vacation, or resident rotation in a teaching hospital. These adverse events often occur during unstructured times of day such as in the afternoon or evening hours when their usual therapist may not be available simply due to work schedules. Self-harming patients who are hospitalized often have a prolonged length of stay with a resultant increased likelihood of therapist turn-over. One practical suggestion offered by Ulke et al. (2014) is to provide at-risk patients with a strong working relationship with two therapists thus minimizing the risk of changing therapists during their hospitalization. In an academic teaching setting, this would involve an active relationship with the unit attending psychiatrist or a staff PMHNP—roles not subject to frequent turn-over. Strategies to minimize splitting behaviors that may emerge as patients work with two therapists may include weekly or bi-weekly brief meetings with the patient and both therapists or shared notes or workbooks that the patient and present therapist can initial to formalize what's been discussed or any action plans put in place.

Acute Management of the Self-Harming Patient

The most common intervention used in response to acute NSSI is verbal deescalation—offering support and alternate coping strategies (Foster, Bowers, & Nijman, 2007; James, Stewart, Wright, & Bowers, 2012; Stewart et al., 2012)—as well as negative consequences. These can include restraint, constant observation, wearing nightclothes throughout the day, PRN medications, loss of privileges, movement of patient to a communal area, transfer to another unit, time out, or seclusion (James et al., 2012; O'Donovan, 2007). Often patients are already under some level of special observation when they self-harm—18% according to one study (James et al., 2012).

James et al. (2012) studied safety incident reports on inpatient self-harm in the United Kingdom and found that the majority of self-injury occurs in the evenings and in private areas, such as bedrooms and bathrooms. While their study did not provide diagnostic details, such as presence or absence of psychosis, they reported that most incidents followed "mood, or auditory/visual hallucinations," which they clarify to include "difficult emotions," as well as demonstrations of conflict (such as earlier self-injury, angry outbursts, or conflicts with staff). These findings support the need for staff to increase their availability, visibility, and focus during evening hours and shift changes.

Concerns exist that approaches such as restraint, constant observation, and wearing nightclothes can be emotionally damaging, even as staff struggle for alternatives to maintain safety (James et al., 2012). The move to less punitive, more supportive approaches permeates the newer models of care described in this article and represent a step in the right direction. From the patient perspective, the negative consequences approach, and inconsistently enforced rules, has been reported to be further alienating and can lead patients to feel like survivors of the very care intended to help them survive (Lindgren, Aminoff, & Graneheim, 2015).

Most critical to recovery for the patient who self-injures is the internal shift within themselves that heralds lasting change (Kool, van Meijel, & Bosman, 2009; Mummé, Mildred, & Knight, 2016; Thomassin, Guérin Marion, Venasse, & Shaffer, 2017; Turner et al., 2014). Several authors remarked on and investigated similar themes. Nurses and providers can be present, instill hope, and assist with the development of the patient's self-esteem, but the final and most critical shift to becoming a noninjurer is internal. Kool et al. (2009) outlined six phases to recovery identified in data analysis of interviews: the phase of connecting and setting limits, the phase of increased self-esteem, the phase of increasing self-understanding, the phase of autonomy, the phase of stopping self-injury, and finally the phase of maintenance. These same phases are referenced in Mummé et al.'s review (2016) along with findings which highlight that intrapersonal reasons to stop self-harming outweigh the interpersonal—often patients simply learned better coping skills or came to decide that self-harming was futile.

Patient Observation

Constant observation (CO) or constant special observation (CSO) is frequently employed (O'Donovan, 2007; Ray et al., 2017) for the at-risk patient, but use of increased unit-wide monitoring and intervention has been proven effective and leads to decreased need for CO/CSO (Ray et al., 2017). Psychiatric monitoring and intervention (PMI) is a level of intervention that has staff active on the unit, monitoring the milieu, and

sitting near patients, thus increasing their availability and approachability (Ray et al., 2017; Ray, Perkins, & Meijer, 2011). This is in contrast to another level of observation originally intended as an alternative to CSO and designed specifically for the patient who engages in NSSI and has no urges or thoughts to harm others. Known as psychiatric nursing availability (PNA), this approach designated one nurse to be the "point person" for the patient to seek out when thoughts of self-harming were present and was envisioned as decreasing stress and loss of privacy while increasing the patient's perception of staff availability, caring and engagement (Ray et al., 2011). While the intention was good, PNA was not shown to be beneficial in reducing the use of CSO. The researchers hypothesized that the exclusionary criteria for the PNA level of observation led to its limited use and lack of impact. The PMI level of observation, however, did show significant benefits, which included not only increased staffing presence in milieu but also reduced use of CSO, a sense of increased unit safety, and improved staff satisfaction (Ray et al., 2017).

Inpatient NSSI Prevention

Safety contracts (O'Donovan, 2007) and distraction techniques, such as recreational therapy, video gaming, and puzzles (O'Donovan, 2007; Tofthagen, Talseth, & Fagerström, 2014), are frequently used to discourage and prevent self-harm among inpatients. To these may be added relaxation techniques, displacement strategies (such as drawing on skin with red markers or snapping rubber bands against the wrist), and journaling (Kool et al., 2009; Livesey, 2009). Research suggests that these may be ineffective, however, particularly pertaining to suicide contracts and adolescent use of distraction techniques (O'Donovan, 2007; Puskar & Urda, 2011; Thomassin et al., 2017). More effective, particularly for adolescents, are strategies that include positive reframing and support seeking (Thomassin et al., 2017). Both of these activities, processing strong emotions through conversation and engaging in positive reframing, similar to cognitive restructuring, were shown to significantly moderate the link between poor emotion expression and acts of self-harm (Thomassin et al., 2017).

The beneficial effects of exercise on mild to moderate depression and anxiety has been known for some time. More recently, the correlation between increasing exercise and decreasing rates of NSSI has been shown in outpatient settings (Boone & Brausch, 2016; Jarvi, Hearon, Batejan, Gironde, & Björgvinsson, 2016). Incentivizing the use of exercise equipment as a substitute for self-injury may lead to increased compliance. Unit rewards could be earned and based on the population served, such as extended access to video games for adolescents or off-unit passes for adults. This intervention would not be appropriate for patients with co-occurring eating disorders, however, for whom access to exercise equipment is typically restricted as part of their treatment. Given that 27.3% of patients with an eating disorder reported a lifetime history of NSSI, this is worth noting (Cucchi et al., 2016).

Other strategies that show promise include individual dialectical behavior therapy (DBT) therapy, cognitive behavioral therapy (CBT)–based psychotherapy, and motivational interviewing (MI; Klonsky et al., 2011; Kress & Hoffman, 2008). MI may be most useful in the early stages of contemplating NSSI cessation, given its efficacy with assisting to resolve ambivalence (Klonsky et al., 2011), however, research is still lacking (Klonsky et al., 2011; Kress & Hoffman, 2008; Washburn, Richardt, et al., 2012). For this reason, Kress and Hoffman (2008) advised the use of MI only as an adjunct to more evidence-based practices. Hawton et al. (2016) systematic review, *Psychosocial Interventions for Self-Harm in Adults*, reported promising results of moderate quality evidence with CBT preventing repetition of NSSI, although there is no indication that it reduces overall frequency of self-harm. Hawton et al. (2016) did not specify which diagnostic categories or populations of those adults who self-harm may especially benefit from this intervention.

For those who self-harm and have comorbid personality disorders, Hawton et al. (2016) found some encouragement for self-injury frequency reduction from therapies that include DBT, mentalization (a psychodynamic approach which focuses on increasing the patient's understanding their own and others' emotional states), and group-based emotion-regulation therapies. Combining DBT and mentalization-based group therapies in the inpatient setting led to significantly reduced self-injury as compared to DBT alone in Edel, Raaff, Dimaggio, Buchheim, and Brune's (2017) research. Turner et al. (2014) suggested several of these therapies show promise for reducing NSSI, if not stopping it, and mentioned DBT, as well as CBT, emotion regulation therapy, medication management, and manual-assisted cognitive therapy. Manual-assisted cognitive therapy is a brief, problem-focused treatment that consists of the patient and therapist working through a 6-chapter manual together with the patient practicing new skills independently between sessions (Evans, Tyrer, Catalan, & Schmidt, 1999). Among the adolescent population, Hawton, Witt, Taylor Salisbury, Arensman, Gunnell, Townsend, et al. (2015) systematic review found only one approach in a small trial led to any reduced frequency of repetition: mentalization. Hawton, Witt, Taylor Salisbury, Arensman, Gunnell, Townsend, et al. (2015) review also stated that further research is

warranted for mentalization therapy, as well as for DBT and therapeutic assessments.

Models of Care

Three models of care have been empirically tested and were reviewed: the Safewards Model (Bowers et al., 2015), the Oakwood Young People's Centre (Livesey, 2009), and the Alexian Brothers Self-Injury Recovery Model (Washburn, Gebhardt, Styer, Juzwin, & Gottlief, 2012). These models share commonalities of removing sharp objects, potential ligature points and materials, pens, and limiting access to certain toiletries such as nail files, aerosol sprays, mouth washes, and tweezers (Cardell, Bratcher, & Quinnett, 2009; O'Donovan, 2007; Sine, 2008).

The Safewards Model (Bowers et al., 2015) is noteworthy and exciting as it offers 10 practical interventions shown to reduce conflict and containment. While the study was not focused solely on reducing NSSI, this was a clearly delineated measure for success in this cluster randomized control trial where 16 wards across 15 hospitals implemented the new model and 15 were given a control model to follow. Successful interventions included "soft words" for addressing potential conflicts (brief scripts for staff), a deescalation model, including positive statements about each patient during shift report, sharing innocuous personal information between patients and staff in a designated "know each other" folder, and a "crate of distraction and sensory modulation tools" (such as stress toys and MP3s with relaxing music; Bowers et al., 2015).

This stands in stark contrast to the Oakwood Young People's Centre, which utilizes a zero-tolerance policy and views NSSI as analogous to violence toward others or illicit substance use (Livesey, 2009). With any act of self-injury, the patient is immediately suspended with a follow-up meeting to discuss the terms of return. Their program also employs a variety of alternate coping tools (ice, rubber bands, red markers, and so on) as well as therapies to address the underlying distress. They report no one has been discharged from their program for a repeat episode of self-harming and show a sharp drop in the rates of self-injury from premodel implementation (Livesey, 2009). From April 2002 to September 2002, they had a mean number of 1.2 episodes of self-harming per week (SD = 1.3), with a sharp increase to a weekly mean of 8.1 episodes over 3 months (SD = 4.0) from October to December 2002. After implementation of their zero-tolerance approach, they now have a mean of 0.2 episodes per week (SD = 0.59), with the last incident in 2006. While the Centre acknowledged some initial internal concerns with appearing punitive, they stressed the supportive measures offered to patients and the consistency among staff for enforcing the policy. They also report confidently that they are monitoring that patients do not develop alternate self-injurious behaviors that are not covered under their zero-tolerance policy. Given that their average length of stay is 6 months and their patients are often allowed to go home on the weekends, the Oakwood approach is unlikely to be applicable to short-stay inpatient units. In addition, and despite these results, the authors point to the research that supports the impact of cognitive reframing, DBT, mentalization, and assisting the patient to self-motivate for change, as opposed to bending to external motivators which will disappear when the patient is discharged (Hawton et al., 2016; Mummé et al., 2016; Thomassin et al., 2017; Turner et al., 2014).

The Alexian Brothers Self-Injury Recovery Model addresses NSSI with co-occurring disorders in the inpatient setting and is envisioned as a way to stabilize the patient while in acute care and pave the way for a more successful outpatient treatment by addressing both mental health conditions in an integrated, rather than piecemeal approach (Washburn, Gebhardt, et al., 2012). The model begins with the assumption that both disorders are manifestations of the same underlying vulnerabilities, although the possibility that they are independent disorders is determined at the outset. For example, a patient may have both an eating disorder and NSSI—each with compulsive, even obsessive-compulsive disorder qualities. If the disorders are determined to be independent, however, the co-occurring disorder is addressed with interventions specific to that concern. The model then addresses underlying vulnerabilities, and the functions the disorders may serve, by addressing them with a three-pronged approach toward strengthening intrapersonal processes, interpersonal processes, and physical–spiritual needs. One key component of the model is including the patient in their own clinical formulation and ongoing assessment as a means to facilitate them moving from a more passive stance to a proactive position, or from "victim" to "survivor" (Washburn, Gebhardt et al., 2012). While promising, the authors acknowledge their approach still lacks empirical support.

Harm Minimization

A few programs, particularly in the United Kingdom, have shifted to the harm minimization approach, with the philosophy akin to needle programs that aim to minimize the effects of intravenous substance use. These programs allow patients to self-harm with varying degrees of staff oversight and availability with the ultimate goal that patients will stop on their own as the underlying sources of distress are managed (Holley, Horton, Cartmail, & Bradley, 2012; James, Samuels, Moran, & Stewart,

2017). Needless to say, there is much controversy surrounding the practice, with many concerned that allowing for any self-injury is tantamount to endorsing it (Gutridge, 2010).

Units that use this approach emphasize to the patient a *goal* of noninjury while allowing for controlled injury if the patient is unable to refrain (Holley et al., 2012). While this approach aims toward eventual cessation, the approach allows for the patient to have access to sterile implements and guidance on so-called "safe" self-injury. Gutridge (2010) wrote a compelling philosophical treatise on the nature of whether the patient who self-injures under supervision is truly making an autonomous decision or not and ends by stating that while the staff may be enabling literal harm, under some circumstances this may be preferable to attain lasting change and avoid a greater harm. Attempts to prevent NSSI entirely are noted in self-harming literature to increase distress and sometimes lead to less controlled and more dangerous attempts to get the desired relief (Thomas & Haslam, 2017). These may include biting, opening old wounds, head-banging, restrictive eating, and greater reliance on as-needed medications to escape distress even as the therapeutic relationship with nursing and providers is threatened (Thomas & Haslam, 2017).

While there is a compelling argument to be made that supervised NSSI is in the client's best interest while alternative coping skills are being strengthened, practitioners may, in thinking about the continuum of self-injury, be concerned that such tolerance is tantamount to endorsing suicidality. Sullivan (2018) avowed that harm minimization is often an ethical and sound approach—one that returns dignity and autonomy to the patient while other skills are learned and underlying issues addressed. While unit staff are often understandably reluctant to consider this approach, practitioners who have used it find that patients report an improved sense of empowerment and that it results in both reduced incidents and decreased severity of self-injury (James et al., 2017).

Unit-Based Approaches

Regardless of the overarching theoretical models of care, several unit-based approaches have shown some success. Ercole-Fricke, Fritz, Hill, and Snelders (2016) studied an adolescent unit that uses a collaborative problem-solving approach with patients and staff coming together to address conflict in a nonpunitive atmosphere. Seeing behavioral dysfunction as often arising out of lagging skills and cognitive deficits, this model, based on Ross Greene's theory of collaborative problem solving, aims to work with the child to develop a mutually agreeable solution to problem behaviors. Rates of NSSI decreased significantly from 49% to 44% postimplementation with a concomitant decrease in punitive strategies, and possibly more significantly the mean length of stay for those who self-injure dropped from 44.89 days preimplementation ($SD = 24.86$) to 21.28 days postimplementation ($SD = 21.03$).

Modified short-term inpatient DBT skills-focused programs such as living through distress also show promise with a focus on mindfulness, distress tolerance, interpersonal, and emotion regulation skills offered in four 1-hour sessions each week over a 6-week period (Gibson, Booth, Davenport, Keogh, & Owens, 2014). Forty-nine percent of participants showed reductions in self-harming behavior and 75% or greater followed completion of the program, and these reductions were maintained at the 3-month follow-up. While van den Bosch, Sinnaeve, Hakkaart-van Roijen and van Furth (2014) speak specifically to a 5-day intensive inpatient DBT program that addresses NSSI in the context of BPD, the model is applicable to those without symptoms of BPD as well given other research addressing DBT's efficacy for reducing NSSI frequency (Hawton et al., 2016; Lofthouse & Katz, 2009; Washburn, Richardt, et al., 2012). In their 2012 systematic review of inpatients with diagnoses of BPD, Bloom, Woodward, Susmaras, and Pantalone (2012) found that in six of eight studies self-harming behaviors decreased following inpatient DBT treatment.

One critical change in unit culture would be to move away from a punitive approach. Educating staff to see the patient not as manipulative but as a person doing the best they can is key. A Dutch-training program designed by a team of lay experts and professionals provides 2-day workshops run by both a lay expert and a nursing trainer offered 3 weeks apart, to allow for practice of skills between the training days. Integral to the program is an art exhibit, the telling of the lay expert's personal story, and provision of tools to recognize early signs of imminent self-injury as well as guidance on how to work with patients to develop an individualized treatment plan (Kool, van Meijel, Koekkoek, van der Bijl, & Kerkhof, 2014). Postintervention, participants in the program reported significantly improved scores on scales designed to measure attitudes toward self-harm, empathic approach, and sense of self-efficacy in dealing with patients who self-harm. Training programs such as these emphasize shifting the attitudes of staff and increasing both their knowledge base and skill set with the NSSI population—these are shown to result in more empathic and less restrictive care (Karman, Kool, Gamel, & van Meijel, 2015; Kool et al., 2014). Schoppmann, Schröck, Schnepp, and Büscher (2007) found that the most important nursing interventions included simple physical reassurance, such as touching a hand, to communicate a sense of safety during states of alienation and dissociation.

And finally, there are the approaches of individual nurses, which, of course, may vary widely within any

setting. While unit culture and models of care are critical, even within one setting an individual nurse can have a quality of caring that makes them especially conducive to helping the struggling patient overcome urges to self-harm (Kool et al., 2009; Mummé et al., 2016). Interventions identified as particularly effective include helping the patient to foster a positive self-image, providing hope, offering alternative behaviors and, most important, creating a sense of connection between the nurse and the patient while simply being present (Kool et al., 2009; Mummé et al., 2016; O'Donovan, 2007).

Medication Interventions

For the provider overseeing the patient who engages in NSSI, medication management is a challenge. Pharmacological treatments for NSSI have included SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin–norepinephrine reuptake inhibitors), atypical antipsychotics, opioids, and opioid antagonists (Bresin & Gordon, 2013; Norelli, Smith, Sher, & Blackwood, 2013; Turner et al., 2014). While antidepressants and antianxiety medications aim to treat underlying mood disorders that may prompt NSSI, theories about dysregulation of the endogenous opioid system explain why the rewards of NSSI may be hard to resist without opioids or opioid antagonists. Conflicting theories exist on whether the dysregulation involves higher or lower levels of endogenous opioids (discussed extensively in Bresin & Gordon, 2013).

Turner et al.'s (2014) systematic review reported some benefits from medications that act on the serotonergic, dopaminergic, and opioid systems but cautioned that most results came from trials with small sizes. Their review pointed out earlier researchers who had advocated for treating the co-occurring disorder with a goal to decreasing NSSI behavior. To this end, for example, one might advocate that compulsive NSSI in a patient with obsessive-compulsive disorder traits may benefit from treatment with fluvoxamine (Bandelow et al., 2012). A later systematic review, however, asserted that while several classes of medications are often used, evidence is scant to absent that there is any significant benefit from any of the following: the newer generation antidepressants, low dose fluphenazine, mood stabilizers, or natural products (Hawton, Witt, Taylor Salisbury, Arensman, Gunnell, Hazell, et al., 2015). In one trial, the antipsychotic flupenthixol, offered extremely low-quality evidence of a significant reduction in self-harming behaviors (Hawton, Witt, Taylor Salisbury, Arensman, Gunnell, Hazell, et al., 2015). Similarly discouraging results for the adolescent population were reported by Plener et al. (2018)—no psychoactive medications were found to be effective in reducing NSSI, with the exception of PRN aripiprazole for acutely injuring adolescents with BPD.

Several researchers have been exploring the relationship between NSSI and opioid receptors, and some suggest self-injurers may be more susceptible to opioid-mediated rewards (Bresin & Gordon, 2013). This link seems consistent with the often-addictive nature many patients describe related to self-injury, although research by Victor, Glenn, and Klonsky (2012) found that emotion regulation models match with negative reinforcement findings better than addiction models of NSSI. Individuals—and primates—with a history of NSSI have been shown to have lower resting levels of beta-endorphins and enkephalins (Stanley et al., 2010), and evidence suggests that NSSI leads to elevations of these same (Bresin & Gordon, 2013). Small scale studies enumerated by Bresin and Gordon (2013) offer hope for treatment with naloxone—whether because it blocks opioid receptors and nullifies the relief NSSI offers, or because of other effects of naloxone on the neuroendocrine system. Buprenorphine is also showing some promising results in patients with severe self-injury for whom other treatment options have failed (Norelli et al., 2013; Stanley et al., 2010).

Limitations

By focusing on NSSI as the condition of interest and limiting research that was primarily focused on select personality disorders with a high percentage of parasuicidal behaviors, selection bias may exist and may have resulted in missed interventions that would be effective but are currently confined to one diagnostic population. The aim was to focus on the treatment of NSSI as an entity apart from any specific diagnoses or single population, but this may have unnecessarily limited the results of this review. In addition, there was likely selection bias in the exclusionary criteria of studies that were outpatient focused—there may be untapped outpatient treatments that could be used in the inpatient setting but are not currently being employed.

The field of research into NSSI is still in the early stages of knowledge development. While researchers continue to seek empirical support for effective interventions, clinicians in the field have practical knowledge that is not being disseminated to the wider mental health network. In order to find answers to the immediate clinical question once the paucity of applicable studies was discovered, the decision was made to widen the field of view. Where those studies are included, mention has been made. It is also for this reason that only nine studies were included in the summary of findings table; this was an attempt to hone in on the most applicable studies that met initial specifications.

Conclusions

Self-harming behaviors often come to light while patients are in an inpatient psychiatric setting (James et al., 2012), at which point interventions must be implemented swiftly. With numbers as high as 49.5% of adolescents with diagnosed mental health disorders (Glenn & Klonsky, 2013), and 70% of adult psychiatric inpatients (Swinton et al., 1998) engaged in NSSI, providers must be proactive. Unit staff and providers should be aware that NSSI may encompass an escalation to inpatient suicide (Tishler & Staats Reiss, 2009). Healthy People 2020 lists the first and second Mental Health Status Improvement objectives as reducing the suicide rate and reducing suicide attempts by adolescents (Healthy People 2020, n.d.). With escalating suicide rates a concern, addressing this proven predictor in some patients of future suicide may address these goals as well, albeit indirectly (Liu, 2017).

The PMHNP is in the position of guiding policies and leading the treatment team in management of the inpatient milieu. By researching best practices, and preparing policy guidelines based on these findings, the PMHNP may pave the way to improved care and better outcomes for these patients. Given the trajectory many patients may face once they begin self-harming, the end goal of updating our current practices based on research that is specific for reducing and eliminating NSSI is of paramount importance (Greydanus & Apple, 2011; Guan et al., 2012; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011).

While there exists a dearth of empirical research, as several authors have noted (James et al., 2012; Klonsky et al., 2014; Washburn, Richardt, et al., 2012), ideas for future research abound. Medications that moderate endogenous opioid levels, as well as those that address serotonin levels, must be tested in larger scale studies for more applicability of findings. Studies must be consistent and precise in their use of terminology. NSSI must be clearly delineated from less specific terms, and ambiguous terminology should be eliminated from the research. Research studies with controlled designs are needed, which focus on the inpatient setting. While Lindgren et al. (2015) state, "An international consensus exists about avoiding psychiatric inpatient care for people who self-harm" (p. 82), the reality is that they are admitted frequently. Given this, we must find empirically supported ways to care for them and minimize their future risks, not just for self-harm, but from future suicide. Patients are typically at their most acute on admission and often this is a sentinel moment for change. Progress has been made: Reliable, valid scales are now available that target both the functions and, at times, addictive nature of self-injury. A push is being made for programs that address self-injury in its own right as well as comorbid diagnoses, and recognition of the fact that BPD is a separate entity entirely. While some programs continue to be more punitive in their approach to the patient who self-injures, increasingly this practice is giving way to more enlightened albeit widely differing approaches such as mentalization. Whether research will ultimately support the zero-tolerance approach, the harm minimization model, or some middle-ground remains to be seen. As with so much else in the mental health field, the answers are evolving. What is clear is the impact that individual care providers can make—whether unit staff or prescribers, as well as the primary importance of the internal shift in the patient toward recovery.

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Do Patients Treated With Dignity Report Higher Satisfaction, Adherence, and Receipt of Preventive Care?

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ABSTRACT

PURPOSE Although involving patients in their own health care is known to be associated with improved outcomes, this study was conducted to determine whether respecting persons more broadly, such as treating them with dignity, has additional positive effects.

METHODS Using data from the Commonwealth Fund 2001 Health Care Quality Survey of 6,722 adults living in the United States, we performed survey-weighted logistic regression analysis to evaluate independent associations between 2 measures of respect (involvement in decisions and treatment with dignity) and patient outcomes (satisfaction, adherence, and receipt of optimal preventive care). Then we calculated adjusted probabilities of these outcomes and performed stratified analyses to examine results across racial/ethnic groups.

RESULTS After adjustment for respondents' demographic characteristics, the probability of reporting a high level of satisfaction was higher for those treated with dignity vs not treated with dignity (0.70 vs 0.38, $P < .001$) and for those involved in, versus not involved in, decisions (0.70 vs 0.39, $P < .001$). These associations were consistent across all racial/ethnic groups. Being involved in decisions was significantly associated with adherence for whites, whereas being treated with dignity was significantly associated with adherence for racial/ethnic minorities. The probability of receiving optimal preventive care was marginally greater for those treated with dignity (0.68 vs 0.63, $P = .054$), but did not differ with respect to involvement in decisions (0.67 vs 0.67, $P = .95$).

CONCLUSIONS Being treated with dignity and being involved in decisions are independently associated with positive outcomes. Although involving patients in decisions is an important part of respecting patient autonomy, it is also important to respect patients more broadly by treating them with dignity.

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INTRODUCTION

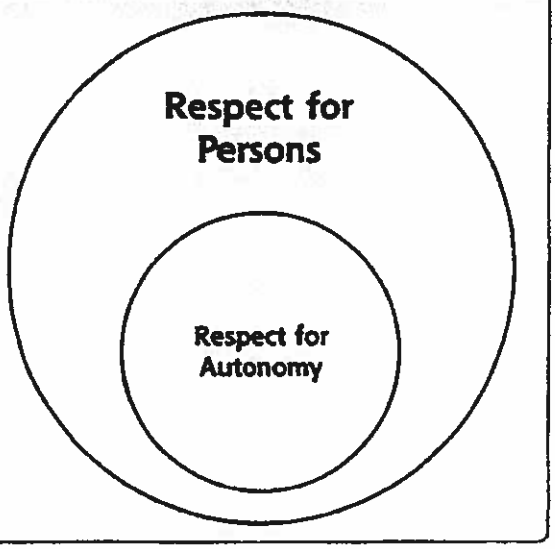
A wide body of research provides strong evidence that links patient involvement in care (and physicians' behaviors that facilitate patient involvement in care) to positive outcomes.[1-15] This literature arguably supports the ethical obligations inherent in the principle of respect for autonomy, a centerpiece of modern bioethics.[16] The principle of autonomy, however, has been criticized in theory and practice for being excessively individualistic, neglectful of emotion, and legalistic.[17-20] North American bioethics has also been criticized in general for being dominated by the culture of "whiteness"[21] and in particular for emphasizing autonomy, because it may be less relevant for some racial/ethnic groups.[22,23] Furthermore, involving patients in their own medical care, although important, may not fulfill the full spectrum of what the term *respect* conveys to many people.[24]

There has been considerably less attention paid, among ethicists and

health services researchers alike, to the broader ethical principle of respect for persons, from which the principle of respect for autonomy is conceptually derived.[16,25] Respect for persons has been broadly defined as the recognition that all persons have dignity or inherent worth.[26] Thus, involving patients in decisions (respect for autonomy) is one important, but not exhaustive, expression of respect for persons (Figure 1).

The purpose of this study was to explore the concepts of respect for persons (treatment with dignity) and respect for autonomy (involvement in decisions) and their possible relation to patient outcomes using data from a nationally representative survey. We hypothesized that both being treated with dignity and being involved in decisions would be independently related to positive outcomes, and that being treated with dignity might be more important to racial/ethnic minorities who have had historical or societal experiences of disrespect.[27,28] Accordingly, the specific aims of this study were (1) to examine the independent contributions of being treated with dignity and being involved in decisions to 3 patient outcomes (satisfaction, adherence, and optimal use of preventive health care), and (2) to examine whether there are differences across racial/ethnic groups in the degree to which being treated with dignity and being involved in decisions are related to positive outcomes.

Figure 1. Theoretical association between respect for autonomy and respect for persons.



METHODS

Study Design and Population

We used data from the nationally representative Commonwealth Fund 2001 Health Care Quality Survey.[29] Respondents included 6,722 adults living in the United States who reported their race as black/African American, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, white, Hispanic/Latino or other/mixed race. This study included all survey respondents who reported their race as white, African American, Hispanic, or Asian (n = 6,299). Respondents who identified themselves as Native Hawaiian/Pacific Islander, American Indian/Alaska Native, or other/mixed race were excluded from this analysis because the numbers of respondents in these categories were too few for meaningful statistical examination.

Random-digit-dialing methods were used to select respondents and communities with high concentrations of African American, Hispanic and Asian residents were oversampled. As many as 20 repeated telephone call attempts were made to solicit participation in the survey, and an overall response rate of 54.3% was achieved. Data were weighted to correct for disproportionate sampling and nonresponse and to make final results more reflective of overall population estimates.

Survey questions covered several domains relating to experiences in the health care system, including usual sources of care and patient-physician communication. In addition, several questions focused on other characteristics of respondents, such as socioeconomic status, self-rated health status, health literacy, primary language spoken in the home, and foreign-born status. The survey was pilot tested, revised, and translated into several languages before final administration. Telephone interviewers who were trained in survey administration offered respondents the option of answering the survey questions in several languages other than English, including Spanish, Mandarin, Cantonese, Vietnamese, and Korean. This study was reviewed and deemed exempt by the Johns Hopkins Institutional Review Board.

Study Variables

All independent and outcome variables were based on patients' perceptions of their health care, reported in response to a number of multiple-choice questions in the survey. The primary independent variables were 2 items inquiring about different expressions of respect during the patient's last encounter with a doctor: "Did the doctor involve you in decisions about your care (as much as you wanted, almost as much, less than you wanted, a lot less than you wanted)?" and "Did the doctor treat you with (a great deal of) respect and dignity (a fair amount, not too much, none at all)?"

The primary outcome variables were patient satisfaction, adherence, and receipt of optimal preventive services. We measured satisfaction and adherence with single survey items: "Overall, how satisfied or dissatisfied

are you with the quality of health care you have received during the last 2 years (very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied)?" and "Has there been a time in the past 2 years when you didn't follow a doctor's advice or treatment plan, get a recommended test or see a referred doctor (yes or no)?" We created a dichotomous variable "optimal preventive care" that was a combination of responses to several survey items. Respondents were asked about their receipt of age- and sex-appropriate preventive services: Papanicolau testing within the past 3 years for all women, mammography within the past 2 years for women aged 50 years and older, any history of colorectal screening for all respondents aged 50 years and older, and cholesterol testing within the past 5 years for men aged 35 years and older and for women aged 45 years and older.[30] For respondents to be classified as receiving optimal preventive care in our analysis, they would need to have had all services for which they were eligible based on age and sex. Men younger than 35 years were excluded from this analysis because there were no items eliciting appropriate preventive services for these respondents.

Statistical Analysis

We dichotomized the 2 survey items measuring different expressions of respect to compare the highest ranking categories ("being involved in decisions as much as wanted" and "being treated with a great deal of respect and dignity") with other responses, based on the positively skewed distribution of responses. Similarly, based on the positive skew of responses regarding patient satisfaction, we dichotomized this outcome variable to compare the highest ranking category (very satisfied) with all other responses. Patient adherence was naturally dichotomous (possible survey responses were yes or no) and receipt of optimal preventive services was created as a dichotomous variable as described above.

We performed separate logistic regression analyses to evaluate the associations of our 2 different measures of respect with each of our 3 outcome variables individually in both unadjusted and adjusted analyses. To determine the extent to which respect for persons and respect for autonomy were independently associated with the 3 outcomes of interest, we adjusted for both types of respect and—in the final model—included patient demographic characteristics as covariates. To help identify demographic characteristics that might act as confounders in the relations between our 2 measures of respect and 3 outcomes, we used χ^2 tests to compare respondents who reported being involved in decisions and being treated with respect/dignity across age, race/ethnicity, sex, income, language spoken, education, and insurance categories. Patient demographic characteristics that were significantly ($P < .05$) related to either independent variable and to at least 1 of the outcome variables were included in the final multivariate models as covariates. Because odds ratios tend to overestimate the probability of frequent events, we present adjusted probabilities for all logistic regression models. These compare respondents treated with different levels of respect while holding all covariates in a given model constant at the mean value (for continuous variables) or the average probability of belonging in a particular category (for dichotomous variables) and thus allow comparisons among otherwise equivalent respondents.[31]

Finally, stratified analyses were performed for each racial/ethnic group separately to explore the degree to which race/ethnicity modifies the relationship of respect with the outcomes of interest. To explore more fully the study hypothesis that respect for persons vs respect for autonomy has different levels of importance for racial/ethnic minorities as compared with whites, post hoc analyses were performed on an aggregate of all racial/ethnic minority respondents to increase statistical power and the ability to detect such differences. To examine whether our findings were influenced by differences across ethnic groups in the interpretation of questions when the survey was administered in different languages, we repeated the stratified analyses limited to respondents who completed the survey questions in English. We conducted all analyses with Stata 7.0[32] using weighted techniques for interpreting survey data.

RESULTS

Characteristics of Study Sample

The total study yielded 6,722 responses (54.3% response rate). Of the 6,722 respondents who participated, we limited our analysis to the 5,514 who reported having had a medical encounter within the past 2 years and who reported their race as white (n = 3,150), African American (n = 926), Hispanic (n = 947), or Asian (n = 491). Most respondents were female (65%), had at least some college education (62%), had incomes of more than 200% of the poverty level (66%), and spoke English as their primary language (93%). Characteristics of the study sample are described in detail elsewhere.[19,33,34]

Overall, 76% of respondents reported being treated with a great deal of respect and dignity, and 77% reported being involved in decisions to the extent that they wished. There were no differences in the percentage of respondents reporting either type of respect by sex or education, yet there were differences in reports of involvement in decisions and treatment with dignity across age, race/ethnicity, and income, as shown in Table 1. The Pearson correlation coefficient between treatment with dignity and involvement in decisions

Table 1. Percentage of Respondents Reporting Different Types of Respect

Characteristic	Number (% of total)	Treated with Dignity* %	Treated with Dignity* P Value	Involved in Decisions† %	Involved in Decisions† P Value
Age, years					
18-39	2,394 (44)	70		74	
40-64	2,236 (41)	79	<.0001	77	.0002
>65	815 (15)	85		84	
Sex					
Male	1,936 (35)	75	.2266	76	.4005
Female	3,578 (65)	77		78	
Race/ethnicity					
White	3,150 (57)	77		77	
African American	926 (17)	75	<.0001	75	<.0001
Hispanic, Latino	947 (17)	76		67	
Asian	491 (9)	59		59	
Primary language					
English	5,118 (93)	76	.0006	78	.0042
Non-English	396 (7)	86		68	
Income					
Below poverty	592 (13)	75		71	
100%-200% poverty	936 (21)	70	.0032	76	.0347
>200% poverty	3,032 (66)	78		78	
Education					
High-school incomplete	660 (12)	76		74	
High-school complete	1,410 (26)	74	.4485	79	.1878
Some college	1,480 (27)	77		78	
College +	1,940 (35)	78		76	
Insurance					
Uninsured	695 (13)	67	<0001	67	<.0001
Insured	4,803 (87)	77		79	

* Percentage of selected demographic category compared with not being treated with dignity.
† Percentage of selected demographic category compared with not being involved in decisions.

was 0.361. Most respondents (62%) reported both being treated with dignity and being involved in decisions, although there were 12% who reported being treated with dignity only (without being involved in decisions), 12% who reported being involved in decisions only (without being treated with dignity), and 14% who reported neither.

Treatment with Dignity and Patient Outcomes

In the overall analysis (Table 2), respondents who reported being treated with dignity were more likely to report higher levels of satisfaction, adherence to therapy, and receipt of optimal preventive services. The associations between being treated with dignity and all outcomes (satisfaction, adherence, and receipt of optimal preventive care) remained significant after adjustment for being involved in decisions; however, after adjustment for demographic characteristics, only satisfaction remained significantly associated with being treated with dignity.

In stratified analyses (Table 3), being treated with dignity was related to patient satisfaction for all racial/ethnic groups. Being treated with dignity was not associated with adherence for any of the racial/ethnic groups separately, but was associated with adherence for minority respondents together in a combined analysis (data not shown in Table 3: adjusted probability 0.81 if treated with a great deal of dignity vs 0.74 if not treated with a great deal of dignity, P = .041). Being treated with dignity was associated with receipt of optimal preventive care for Latino respondents separately and for all minority groups in a combined analysis (data not shown in Table 3: adjusted probability 0.72 if treated with a great deal of dignity vs 0.63 if not treated with a great deal of dignity, P = .015).

Involvement in Decisions and Patient Outcomes

In overall analysis (Table 2), being involved in decisions was associated with patient satisfaction and adherence. It remained independently associated with patient satisfaction and adherence even after adjustment for being treated with dignity and patient demographic covariates. Being involved in decisions was not associated with receipt of optimal preventive care.

In stratified analyses (Table 3), being involved in decisions was associated with patient satisfaction for all racial/ethnic groups separately. Being involved in decisions was associated with adherence for white respondents, but not for respondents of any other racial/ethnic group either separately or combined (data not shown in Table 3: adjusted probability 0.80 for all minority respondents combined if involved in decisions vs 0.77 if not involved in decisions, P = .412). Finally, being involved in decisions was not associated with receipt of optimal preventive care patients of any race/ethnicity; however, this association was of borderline statistical significance (P = .05) for Latino respondents who appeared somewhat more likely to receive optimal preventive services when they reported as much involvement in decision making as they desired. These

Table 2. Probabilities of Positive Patient Outcomes

Involvement With Health Care	Satisfaction		Adherence		Optimal Preventive Care	
	AP (95% CI)	P Value	AP (95% CI)	P Value	AP (95% CI)	P Value
Treated with dignity						
Unadjusted						
A great deal	0.73 (0.71-0.75)	<.001	0.78 (0.76-0.80)	<.001	0.66 (0.64-0.68)	.009
Less than a great deal	0.33 (0.29-0.37)		0.69 (0.65-0.72)		0.60 (0.57-0.64)	
Adjusted for involvement in decisions						
A great deal	0.71 (0.69-0.73)	<.001	0.77 (0.75-0.79	.008	0.66 (0.64-0.68)	.019
Less than a great deal	0.38 (0.34-0.42)		0.71 (0.69-0.75)		0.61 (0.56-0.65)	
Adjusted for demographics* and involvement in decisions						
A great deal	0.70 (0.68-0.72)	<.001	0.77 (0.75-0.79	.096	0.68 (0.66-0.70)	.054
Less than a great deal	0.38 (0.34-0.43)		0.73 (0.69-0.77)		0.63 (0.58-0.67	
Involved in decisions						
Unadjusted						
As much as desired	0.72 (0.70-0.74)	<.001	0.78 (0.76-0.80)	<.001	0.66 (0.63-0.68)	.235
Less than desired	0.34 (0.30-0.38)		0.67 (90.63-0.71)		0.63 (0.59-0.67)	
Adjusted for treatment with dignity						
As much as desired	0.70 (0.68-0.72)	<.001	0.78 (0.76-0.79)	<.001	0.65 (0.63-0.67)	.841
Less than desired	0.41 (0.36-0.45)		0.69 (0.65-0.72)		0.64 (0.60-0.68)	
Adjustment for demographics* and treatment with dignity						
As much as desired	0.70 (0.68-0.72)	<.001	0.78 (0.76-0.80)	<.001	0.67 (0.66-0.70)	.953
Less than desired	0.39 (0.35-0.44)		0.69 (0.65-0.73)		0.67 (0.62-0.71)	

AP = adjusted probability; CI = confidence interval.

* Demographics included respondent age, sex, race/ethnicity, income, insurance, and primary language.

findings did not differ when the analysis was limited to respondents across racial/ethnic groups who completed the survey in English.

DISCUSSION

Patient involvement in care has been associated in previous studies with many positive health outcomes.[1-15] Our results underscore the important need to go beyond simply involving patients in decisions to respecting persons more broadly by also treating them with dignity. In other words, involving patients in care does not capture the full importance of treating them with dignity, at least insofar as both are associated with positive outcomes.

Perhaps the most interesting finding in this study is the association between treatment with dignity and receipt of optimal preventive care, consistent across all racial/ethnic groups, which is stronger than the association between being involved in decisions and receiving optimal preventive care. It is possible that no association between being involved in decisions and receipt of optimal preventive care was observed because most preventive service recommendations are clear and do not present many options. So, why might being treated with dignity be associated with receipt of optimal preventive care? In contrast to patient adherence (which is a measure of patient behavior), receipt of optimal preventive services requires particular behaviors on the part of both the clinician and the patient—the clinician to recommend the service and the patient to actually have it done. Perhaps patients who are treated with dignity are more likely to pursue recommended interventions. Alternatively, physicians who treat their patients with dignity (that is, those who recognize the inherent value in their patients) might be more likely to ensure that their patients receive optimal preventive services. We do not know from our study whether patients who did not receive optimal preventive care were not prescribed optimal preventive care, or whether they chose not to seek it. Receipt of optimal preventive care was the only quality of care indicator that we evaluated in this study, but it is possible that treatment with dignity is more closely related to quality of care in general than is involvement in decisions. Further research is needed to explore this hypothesis.

It is difficult to interpret these data without wondering what being treated with dignity actually means. Involving patients in decisions may seem fairly straightforward in comparison with the more ambiguous notion of treating patients with dignity. We suggest that treating someone with dignity primarily involves recognizing inherent value in that person. Data from

Table 3. Adjusted Probabilities of Positive Patient Outcomes Across Race/Ethnicity

Involvement With Health Care	Satisfaction AP (95% CI)	Satisfaction P Value	Adherence AP (95% CI)	Adherence P Value	Optimal Preventive Care AP (95% CI)	Optimal Preventive Care P Value
Treated with dignity*						
Whites (n = 3,488)						
A great deal	0.71 (0.68-0.74)	<.001	0.74 (0.71-0.77)	.388	0.66 (0.61-0.71)	.367
Less than a great deal	0.40 (0.34-0.47)		0.71 (0.66-0.76)		0.75 (0.56-0.70)	
African Americans (n = 1,037)						
A great deal	0.73 (0.67-0.79)	<.001	0.79 (0.73-0.83)	.124	0.75 (0.69-0.80)	.406
Less than a great deal	0.35 (0.25-0.46)		0.71 (0.61-0.79)		0.70 (0.59-0.79)	
Latinos (n = 1,153)						
A great deal	0.73 (0.65-08.80	.001	0.83 (0.77-0.87)	.456	0.73 (0.66-0.79)	.039
Less than a great deal	0.52 (0.40-0.63)		0.79 (0.68-0.87)		0.59 (0.47-0.71)	
Asians (n = 621)						
A great deal	0.56 (0.45-0.66)	<.001	0.80 (0.70-0.87)	.202	0.62 (0.51-0.71)	.231
Less than a great deal	0.18 (0.10-0.28)		0.71 (0.58-0.81)		0.52 (0.38-0.66)	
Involved in decision†						
Whites (n = 3,488)						
As much as desired	0.71 (0.68-0.74)	<.001	0.76 (0.73-0.79)	<.001	0.65 (0.60-0.70)	.481
Less than desired	0.39 (0.33-0.46)		0.64 (0.68-0.69)		0.67 (0.60-0.73)	
African Americans (n = 1,037)						
As much as desired	0.70 (0.6400.76)	<.001	0.78 (0.72-0.83)	.433	0.74 (0.68-0.80)	.585
Less than desired	0.44 (0.33-0.55)		0.74 (0.64-0.82)		0.71 (0.60-0.80)	
Latinos (n = 1,153)						
As much as desired	0.74 (0.67-0.81)	<.001	0.82 (0.76-0.87)	.711	0.72 (0.66-0.78)	.051
Less than desired	0.46 (0.35-0.58)		0.80 (0.70-0.88)		0.61 (0.48-0.72	
Asians (n = 621)						
As much as desired	0.50 (0.39-0.61)	.018	0.78 (0.68-0.85)	.876	0.57 (0.46-0.67)	.336
Less than desired	0.28 (0.17-0.42)		0.77 (0.64-0.86)		0.65 (0.51-0.77)	

AP = Adjusted probability; CI = confidence interval.

* Probability adjusted for respondent age, sex, incomve, insurance, primary language, and being involved in decisions.

† Probability adjusted for respondent age, sex, incomve, insurance, primary language, and being treated with dignity.

this study, however, do not offer an account of the specific behaviors that are associated with such a valuing. Indeed, the item used in the survey did not specify what being treated with dignity entailed, and so we do not have a clear notion of what respondents were thinking when they answered the question. We suggest that patients are somehow able to determine when clinicians present a valuing attitude, and this perception seems to correlate with important outcomes. These perceptions may correlate with whether the patient was treated kindly or rudely. Further research is needed to understand what clinician behaviors are interpreted by patients as an indication of treatment with dignity.

Finally, our study found that the associations between these 2 forms of respect and most patient outcomes (except patient report of adherence) were consistent across racial/ethnic groups. This aspect of our study provides some input into the question of how respect is conceptualized from the perspectives of patients.[21] Furthermore, in the case of adherence, our data suggest that being treated with dignity might be more important to racial/ethnic minorities than it is to whites. This finding is important because the modern bioethical concept of respect highlights autonomy, which inadequately captures the notion of dignity. Our data suggest the need to expand the definition of respect, not to negate the importance of respecting autonomy. Our data also suggest that, in future studies, it might be important to measure directly the value that patient's place on the different dimensions of respect for autonomy and respect for persons. Nonetheless, even where our study finds that one of these forms of respect was not associated with positive patient outcomes for a particular racial/ethnic group, we suggest that both forms of respect are owed to all patients on moral grounds alone.

These results have several important implications for practicing clinicians, medical educators, researchers, and medical ethicists. Practicing clinicians ought to consider how to foster their own attitudes of respect-

fulness toward patients by engaging in self-reflection or participating in educational or training programs in communication skills and professionalism. Medical educators ought to teach students about the principle of respect for autonomy, as well as foster environments in which patients are regarded as valuable and treated with dignity. After all, the most egregious cases of student-reported physician misconduct no longer seem to be in the realm of paternalism, but in the systematic devaluing of patients.[35] Researchers ought to investigate which behaviors are interpreted by patients as an indication of treatment with dignity and, if our findings are replicated in other studies, to design and evaluate the impact of programs aimed at increasing levels of respect within health care systems.

For ethicists, these data lend support to conceptual arguments for honoring the broader principle of respect for persons that incorporates treating patients with dignity in addition to the narrower responsibility of respecting autonomy. Although respect for persons is conceptualized as the broader principle (Figure 1), our data suggest that patients do not always experience being involved in decisions as an indication of respect more broadly. This finding may be because involving patients in decisions is only one part of respecting autonomy, but it may also be because respect for autonomy is not the full expression of respect, insofar as there are aspects of persons in addition to their autonomy (such as their dignity) that require attention morally.

Our results should be interpreted with several limitations in mind. First, these data are cross-sectional; therefore, causality cannot be attributed to either measure of respect for any of the outcomes. It may be that provision of preventive services, for example, led to increased ratings of respect. Second, the possibility of selection bias exists, because the response rate to the survey was modest (54%), and we do not have data on nonresponders to assess generalizability. Third, there is the potential for unmeasured confounding with any observational study. For example, it is possible that the associations we observed were related to unmeasured patient, physician, or health care system factors; perhaps the types of health care settings in which one experiences disrespect are the same ones in which there is poor quality of care.

Fourth, there is the possibility of information bias (in respondent recall or reporting), given the time reference for the items: treatment with dignity and involvement in decisions were asked of respondents regarding the last medical encounter, whereas satisfaction, adherence, and optimal preventive care refer to general experiences within the past 2 years. Moreover, we relied on patients' self-report of respect, rather than on an approach of direct observation. Although patients may be best positioned to judge whether they have been treated with respect, it is possible that different racial/ethnic groups attach difference connotations to the terms used in survey items. Insofar as post hoc analyses aimed at distinguishing racial/ethnic minority respondents as an aggregate group from white respondents, such between-group differences could also have been underappreciated or overlooked. Although these items did not undergo extensive cognitive testing across languages, it seems unlikely that our findings are simply due to linguistic differences, given that differences across racial/ethnic groups persisted after limiting the analysis to those respondents who completed the survey in English.

Finally, such concepts as respect for persons and respect for autonomy are not perfectly measured by survey items, particularly from single items. Involvement in decisions is one of many ways in which respect for autonomy is expressed. Even so, each of the items used in this study to measure different forms of respect was fairly well representative of the underlying concept involved; thus, the items have face validity. Our study also found that the items possess predictive validity, as shown by their association with important outcomes of interest. Whereas there exist previously validated psychometrically sound instruments to measure involvement in decisions,[2,3,36,37] no such instrument exists to measure being treated with dignity, despite some preliminary efforts to operationalize the concept.[38,39] Future research would benefit from well validated measures of different aspects of respect.

In conclusion, being involved in decisions and being treated with dignity are independently important from patients' perspectives. Complete respect is not limited to respect for autonomy; it also entails regarding the patient as having inherent value. Health professionals ought to involve patients in decisions; however, doing so does not replace treating each patient with respect and dignity.

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Key words: Physician-patient relations/ethics; ethnic groups; personal autonomy; bioethics; respect

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Neuropsychiatric Disease and Treatment

Dove

ORIGINAL RESEARCH

Psychometric properties of the Patient Dignity Inventory in an acute psychiatric ward: an extension study of the preliminary validation

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Background: During the last decades, dignity has been an emerging issue in mental health since its ethical and therapeutic implications became known. This study is an extension of the preliminary validation of the Patient Dignity Inventory (PDI) in a psychiatric setting, originally designed for assessing perceived dignity in terminal cancer patients.

Methods: From October 21, 2015 to December 31, 2016, we administered the Italian PDI to all patients hospitalized in an acute psychiatric ward, who provided their consent and completed it at discharge (n=165). We performed Cronbach's alpha coefficient and principal factor analysis. We administered other scales concomitantly to analyze the concurrent validity of PDI. We applied stepwise multiple linear regression to identify the patients' demographic and clinical variables related to the PDI score

Results: Our response rate was 93%, with excellent internal consistency (Cronbach's alpha coefficient=0.94). The factorial analysis showed three factors with eigenvalue >1, which explained >80% of total variance. 1) "loss of self-identity and anxiety for the future", 2) "concerns for social dignity and spiritual life", and 3) "loss of personal autonomy". The PDI and the three factor scores were positively and significantly correlated with the Hamilton Scales for Depression and Anxiety but not with other scale scores. Among patients' variables, "suicide risk" and "insufficient social and economic condition" were positively and significantly correlated with the PDI total score.

Conclusion: The PDI can be a reliable tool to assess patients' dignity perception in a psychiatric setting, which suggests that both social and clinical severe conditions are closely related to dignity loss

Keywords: dignity perception in psychiatry, patient dignity inventory, patients hospitalized in an acute psychiatric ward, severe psychiatric diseases, suicide risk, insufficient social and economic condition

Introduction

Dignity in mental health

During the last decades, dignity has been an emerging issue in medicine and, in particular, in mental health. It embodies not only the fundamental human right to avoid discrimination, stigmatization, and marginalization, as World Health Organization[1] stated but also represents a "means to recovery", in accordance with the Kogstad's study.[2] Jacobson showed that the perception of dignity can explain the mutual relationship between health and human rights, suggesting that violation of dignity can result from asymmetrical relationships in vulnerable patients with disabling diseases.[3]

In mental health, dignity is closely associated with the concept of recovery, and a means of developing "new meaning and purpose in one's life as one grows beyond the

catastrophic effects of mental illness".[4] Respecting patients' identity and dignity represents a fundamental element of the therapeutic approach to patients affected by mental diseases.[2,5,6] "Listening to patients' views on the specific factors they consider useful to maintain their dignity" can preserve it, improving the therapeutic approach.[7,8] Dignity and other four descriptive categories (security, participation, recovery and the care environment) emerged from the study of Schroeder et al[9] who explored patients' perceptions of quality of care. Dignity and autonomy represent key targets of personalized patient care, a strategic approach to achieving quality outcomes, as defined by the Social Care Institute for Excellence.[10] A person-centered approach in mental health consists of taking care of patient needs and respecting individual's preferences and rights.[11]

In accordance with authors who evaluated the experience of dignity among elderly adults with schizophrenia, the perception of self-dignity can be reduced by "ageism, stigma, discrimination, and alienation", whereas, in contrast, it can be supported by a therapeutic recovery-focused relationship.[12]

Care aimed at preserving dignity has been proposed as a "person-centered approach", which can reduce the psychosocial and existential burden related to chronic and severe illnesses, and, at the same time, improve the outcomes of treatment.[13]

Dignity in an acute psychiatric ward

The difficulties of maintaining dignity in acute mental health wards have been documented by many authors in different countries.[14–19]

A qualitative study[20] reported the experience of inpatient care as "a struggle for dignity in the face of discrimination and rejection". The Mental Health Act Commission's 2008 biennial report found conditions in acute psychiatric wards to be "tougher and scarier" than they were 10 years previously.[21]

Campbell[22] pointed out that the experience of a troubled hospitalization in a psychiatric ward could be as traumatic as the nervous breakdown that precipitated the hospitalization itself.

Environmental issues that can threaten dignity in acute wards include overcrowding and poor staffing (both in number and quality). Curtice and Exworthy[23] identified environmental threats to dignity, including lack of privacy on mixed-gender wards and impoverished or unclean environments. Excessive bed demand and overoccupancy of acute psychiatric wards and facilities can further "exacerbate difficulties in maintaining the safety, dignity, and privacy of patients".[21]

Patient dignity inventory

The Patient Dignity Inventory (PDI)[24] is one of the few available instruments for measuring dignity, developed by Chochinov in accordance with his model of dignity conserving care in the terminally ill patients.[24,25] The PDI consists of 25 items aimed at investigating three primary domains of the model: 1) illness-related concerns, comprising level of independence and symptoms distress; 2) dignity conserving repertoire, consisting of dignity conserving perspectives and practices; and 3) social dignity inventory.[26] This questionnaire was validated in many languages[27–33] and was also applied in nononcologic settings, such as cardiology units[34] and severely ill outpatient settings.[35] The validation studies demonstrated similar good internal consistency and the existence of more than one factor, with the exception of the Italian study in oncology which evidenced only one factor. The preliminary validation study in an acute psychiatric ward highlighted three factors supported by all but two items of the PDI, which represented the main domains of dignity, excellent internal consistency and statistically significant positive correlation with the Hamilton Scales for both Depression and Anxiety.[36]

Aims

To extend the preliminary validation of PDI among patients hospitalized in an acute psychiatric ward and identify demographic and clinical variables related to PDI score.

Methods

Study design

Although PDI was originally designed for assessing perceived dignity-related distress in terminal cancer patients, its administration in a psychiatric setting can be justified by the high risk of loss of dignity potentially induced by both cancer illness and psychiatric disorders, especially if they are severe, chronic, disabling, and/or if they require hospitalization. Given the universality of dignity, the author of the PDI suggested its use in many different health contexts.[24]

We administered the Italian version of the PDI, initially validated in an oncology setting[28] and successively modified for a psychiatric context in our preliminary validation study.[36] The two slightly amended items were the following:

- No. 3: "physically distressing symptoms" was changed to "experiencing physically distressing symptoms (such as pain, shortness of breath, nausea) for example, adverse drug effects".
- No. 17: "concerns regarding spiritual life" was changed to "concern that my spiritual life is not meaningful".

The PDI consists of 25 items that can be evaluated on a five-point scale ranging from "no problem", equivalent to the minimum score of 1, to "an overwhelming problem", associated with the maximum score of 5. Following the methodology of validation research,[24,28] we concomitantly administered additional scales in order to evaluate the concurrent validity of the PDI main domains comparing them to standard validated measures. We used Hamilton Rating Scale for Depression (Ham-D),[37] Hamilton Anxiety Rating Scale (Ham-A),[38] and Global Assessment of Functioning (GAF).[39] Moreover, we evaluated the correlation of PDI with the Health of the Nation Outcome Scales (HoNOS),[40] a questionnaire routinely used at admission and discharge of all patients in our psychiatric ward.

Sampling strategies

To determine an adequate sample size for performing factor analysis, we recruited five subjects per variable, according to "the rule of 5" in the subjects-to-variables ratio.[41]

We administered the PDI among patients hospitalized in the Service of Psychiatric Diagnosis and Treatment (SPDT) ward of a northern Italian town. The 15-bed SPDT, as required by Law 180 of 23/05/1978 (later included in Law 833 of 12/23/1978), is located in a General Hospital and serves patients from the related catchment areas with acute mental disorders requiring hospital care in voluntary and involuntary treatments.

We used the following criteria for collecting our sample:

- Inclusion criteria: patients hospitalized for >72 hours, able to understand the questionnaire, to complete it independently, and to give us their written informed consent.
- Exclusion criteria: patients hospitalized for <72 hours, affected by medium or severe intellectual disability, dementia or severe cognitive deterioration with Mini-Mental State Examination <24,[42] minors, no knowledge of Italian language, previous administration of PDI.

Working method and study period

We chose to administer the PDI during the 3-day period before discharge in order to obtain the highest participation and study response from patients due to their clinical improvement compared with the moment of hospital admission. This timing of PDI administration also provided a sense of what impact hospitalization had had on patients in terms of dignity-related distress. At the moment of PDI administration, all patients were voluntarily hospitalized and freely participated in this study, after having provided their informed consent.

Data collection was conducted between October 21, 2015 and December 31, 2016.

Concurrent with the administration of the PDI, other scales described above were administered to each patient (HoNOS was also administered at the moment of admission as indicated by local guidelines).

We selected demographic and clinical variables of our sample from clinical records and information systems of our Mental Health Department, and, when necessary, from the patients' psychiatrists (Tables 1 and 2).

Ethical considerations

Data were collected after the Local Ethical Committee of Modena (3565 Protocol 173/15 Practice) and the Department of Mental Health Service approved this study. This research was conducted following the principles of the World Medical Association Declaration of Helsinki (1964) and according to good clinical practice criteria. Therefore, the written informed consent of each member of our sample was collected and, subsequently, e-mailed to the general practitioner indicating their patient was a participant in the present study.

Table 1 Demographic variables

Variables	Males, n=75 (45%)	Females, n=90 (55%)	Total, n=165 (100%)
Age (mean±SD)			
Years	43.29±14.96	44.57±13.90	43.89±14.42
Nationality, n (%)			
Italian	65 (86)	80 (89)	145 (87)
European extra-Italian	1 (1)	2 (2)	3 (2)
Extra-European	9 (12)	8 (9)	17 (11)
Marital status, n (%)			
Single	52 (69)	41 (45)	93 (56)
Married	19 (25)	25 (27)	44 (27)
Divorced/widowed	4 (5)	24 (26)	28 (17)
Schooling, n (%)			
Primary school	11 (15)	10 (11)	21 (13)
Secondary school	25 (33)	27 (30)	52 (31)
High school	31 (41)	36 (40)	67 (41)
Degree	8 (11)	17 (19)	25 (15)
Work activity, n (%)			
Employed	25 (33)	34 (38)	59 (36)
Unemployed	39 (52)	31 (34)	70 (42)
Retired	6 (8)	15 (17)	21 (13)
Other	5 (7)	10 (11)	15 (9)
Family and surrounding, n (%)			
Single	16 (21)	31 (34)	47 (28)
Parental family	39 (52)	22 (24)	61 (37)
Marital family	17 (23)	34 (38)	51 (31)
Community/ residential facility	3 (4)	3 (3)	6 (4)
Social and economic conditions, n (%)			
Sufficient	63 (84)	74 (82)	137 (83)
Insufficient	12 (16)	16 (17)	28 (17)

Table 2 Clinical variables

Variables	Males, n=75 (45%)	Females, n=90 (55%)	Total, n=165 (100%)
Psychiatric illness duration (mean±SD)			
Years	9.35±9.55	9.80±9.08	9.58±9.28
Previous psychiatric hospitalizations, n (%)			
First psychiatric hospitalization	31 (41)	27 (30)	58 (35)
One or more previous psychiatric hospitalizations	44 (59)	63 (70)	107 (65)
Psychiatric diagnosis at discharge (ICD-9CM), n (%)			
Schizophrenic and other psychotic disorders	30 (40)	39 (43)	69 (42)
Bipolar disorders, manic episode	16 (21)	21 (23)	37 (22)
Personality disorders	18 (24)	18 (20)	36 (22)
Anxious disorders and dysthymia	7 (9)	6 (7)	13 (8)
Organic psychosis	2 (3)	4 (4)	6 (4)
Other	2 (3)	2 (2)	4 (2)
Organic comorbidity, n (%)			
Present	29 (38)	34 (37)	63 (38)
Absent	46 (61)	56 (63)	102 (62)
Substance abuse, n (%)			
Present	30 (40)	20 (23)	50 (30)
Absent	45 (60)	70 (77)	115 (70)
Duration of hospitalization (m±SD)			
Days	16.04±20.94	16.16±13.40	15.96±17.22
State of hospitalization, n (%)			
Involuntary treatment	28 (37)	47 (52)	78 (47)
Voluntary treatment	50 (66)	40 (44)	87 (53)
Destination at discharge, n (%)			
Home	45 (60)	59 (65)	104 (63)
Transfer to private hospital	24 (32)	25 (28)	49 (30)
Transfer to community or residential facilities	6 (8)	6 (7)	12 (7)
Need for supplementary laboratory and clinical tests, n (%)			
Present	37 (49)	39 (43)	76 (46)
Absent	38 (51)	51 (57)	89 (54)
Drug administration, n (%)			
Oral	50 (47)	56 (42)	106 (64)
Parental or more than one route	25 (53)	34 (58)	59 (36)
Outpatient service therapeutic-rehabilitative programs, n (%)			
Present	69 (92)	80 (89)	149 (90)
Absent	5 (7)	10 (11)	15 (10)
Suicide risk, n (%)			
Present	18 (24)	17 (19)	35 (21)
Absent	57 (76)	73 (81)	130 (79)

Abbreviation: ICD-9CM, International Classification of Diseases, 9th Revision, Clinical Modification

Statistical analysis

Descriptive statistical analysis was performed for demographic and clinical variables: mean±SD for continuous data and percentages for categorical data. The admission and discharge HoNOS scores were compared by paired *t*-test. The PDI content and face validity were assessed before the administration of the questionnaire as reported in the preliminary research.[36] The content validity was discussed among the researchers and the face validity was initially assessed by the first 20 patients of our sample in order to evaluate their capacity to understand and answer the questionnaire. We investigated the internal consistency of the PDI to assess the structural validity and explored its dimensions by factor analysis.

The internal consistency of the PDI was evaluated by Cronbach's alpha coefficient. We have performed the principal factor analysis.[43] The factor patterns were computed using the squared multiple correlations as estimates of the communality, followed by the orthogonal varimax rotation.[44] The factors highlighted by the orthogonal rotation were selected according to eigenvalue >1 for each factor (Kaiser's criterion),[45] later confirmed by the scree plot graphical feedback. The items with factor loadings >0.40 on a given dimension were identified as good indicators of each factor.

We applied the oblique rotation of the factors (promax), which allowed the assessment of the factors' interdependence, as sensitivity analysis.[46]

To assess the adequacy of our sample for factor analysis, we applied the Kaiser–Meyer–Olkin measure, which evaluates the sampling adequacy, and the Bartlett's test of sphericity, which tests whether the data come from a normal distribution with zero covariance.[47]

Similarly, to examine internal consistency and concurrent validity of each factor previously identified, we calculated the Cronbach's alpha coefficient for each factor and analyzed the correlation with all other scale scores. We analyzed the PDI concurrent validity by means of the correlation with all other scale scores (Ham-A, Ham-D, GAF, HoNOS; Spearman's rho). We used a backward stepwise multiple linear regression to identify the demographic and clinical variables correlated with the PDI score (dependent variable). Variables with a p-value >0.05 were removed from the model.[48] The same model was applied to evaluate the correlation between the sum of the items that loaded onto the identified factors and other selected variables.

Data were analyzed using STATA Version 12.60.[49]

Results

Sample section

In our study, we obtained a response of 93% since only 12 of 177 individuals to whom the PDI questionnaire was proposed (7%) did not agree to participate for various reasons.

The demographic variables of the 165 patients who participated in the study, 90 females (55%) and 75 males (45%), are shown in Table 1.

Regarding clinical variables, shown in Table 2, our patients suffered from serious psychiatric diseases, according to International Classification of Diseases, 9th Revision, Clinical Modification;[50] 47% of the sample were hospitalized in compulsory state, according to Italian Law 180, with an average length of 3.36 days under compulsory treatment; suicidal risk, routinely confirmed on the basis of a clinical evaluation when patients were admitted, was detected in 21% of our sample.

Regarding the administration of the PDI, almost all patients in the sample stated that they did not encounter any difficulty in understanding the questionnaire, which they completed independently.

PDI validation section

The total score obtained on the PDI averaged 48.58 (± 21.11 SD) as shown in Table 3. All items in the questionnaire, rated on a scale from 1 to 5, presented an average score <3. The 25 items of the PDI questionnaire showed excellent internal consistency, with a Cronbach's alpha coefficient ≥0.93 (Table 3).

Our factorial analysis yielded three initial factors that explained >80% of the cumulative variance of the model, with eigenvalue >1 according to Kaiser's criterion (Table 4). The weight of three factors was graphically confirmed by scree plot (Figure 1). Orthogonal rotation put in evidence the items underlying the three factors with their factor loadings and their uniqueness (Table 5).

From our model, item no. 3 "experiencing physically distressing symptoms (such as pain, shortness of breath, nausea) as drug adverse effects" and item no. 10 "not being able to continue with my usual routines" were excluded because they had factor loading <0.40 and uniqueness >0.70 (Table 5). Each of the three factors showed a good internal consistency: for Factor 1, "loss of self-identity and anxiety for the future" (Cronbach's alpha coefficient=0.93); Factor 2: "concerns for social dignity and spiritual life" (Cronbach's alpha coefficient=0.76); and Factor 3: "loss of personal autonomy" (Cronbach's alpha coefficient=0.81; see Table 5 for details regarding factor loading).

We obtained a value of 0.89 at the Kaiser–Meyer Olkin test (range between 0 and 1), which permitted us to define our sample "meritorious" since it was numerically adequate for factor analysis. Bartlett's test of sphericity (chi-square=2,299.6; df=300; p<0.001) showed that items were not intercorrelated.

The oblique rotation revealed that the same three main factors were positively and partially related to each other (Factors 1 and 2: 0.66; Factors 1 and 3: 0.55; Factors 2 and 3: 0.54).

Ham-D and Ham-A scale scores showed that participants suffered predominantly from mild anxiety and depressive symptoms. The statistically significant correlation between the Ham-D and Ham-A scales scores and the overall score of the PDI showed the concurrent validity of the questionnaire (Table 6). No statistically significant correlation was obtained with the scores of the other scales administered. The HoNOS score at discharge was statistically significantly different from that obtained at admission, indicating an overall clinical improvement of patients at the time of discharge (Table 6).

Correlation between PDI score and demographic and clinical variables

At our multiple linear regression analysis, according to the stepwise model, only some variables were statistically

Table 3 PDI score, inter-item correlations, and Cronbach's alpha coefficient in our sample

PDI items		Mean±SD	Min–max	Item-test, correlation	Cronbach's alpha coefficient
1	Not being able to carry out tasks associated with daily living (eg, washing myself, getting dressed)	1.57±1.13	1–5	0.56	0.94
2	Not being able to attend to my bodily functions independently (eg, needing assistance with toileting-related activities)	1.39±0.93	1–5	0.49	0.94
3*	Experiencing physically distressing symptoms (such as pain, shortness of breath, nausea) as drug adverse effects	1.93±1.17	1–5	0.37	0.94
4	Feeling that how I look to others has changed significantly	1.82±1.19	1–5	0.56	0.94
5	Feeling depressed	2.35±1.47	1–5	0.68	0.94
6	Feeling anxious	2.26±1.37	1–5	0.67	0.94
7	Feeling uncertain about my illness and treatment	1.96±1.22	1–5	0.7	0.94
8	Worrying about my future	2.53±1.47	1–5	0.66	0.94
9	Not being able to think clearly	1.89±1.28	1–5	0.76	0.94
10	Not being able to continue with my usual routines	2.28±1.44	1–5	0.57	0.94
11	Feeling like I am no longer who I was	1.79±1.20	1–5	0.68	0.94
12	Not feeling worthwhile or valued	1.88±1.24	1–5	0.71	0.94
13	Not being able to carry out important roles (eg, spouse, parent)	2.07±1.49	1–5	0.72	0.94
14	Feeling that life no longer has meaning or purpose	1.91±1.32	1–5	0.75	0.94
15	Feeling that I have not made a meaningful and lasting contribution during my lifetime	2.01±1.31	1–5	0.79	0.94
16	Feeling I have "unfinished business" (eg, things left unsaid or incomplete)	2.34±1.34	1–5	0.65	0.94
17*	Concern that my spiritual life is not meaningful	1.60±1.08	1–5	0.53	0.94
18	Feeling that I am a burden to others	2.20±1.49	1–5	0.68	0.94
19	Feeling that I do not have control over my life	2.14±1.43	1–5	0.83	0.94
20	Feeling that my illness and care needs have reduced my privacy	1.97±1.25	1–5	0.59	0.94
21	Not feeling supported by my community of friends and family	1.99±1.32	1–5	0.6	0.94
22	Not feeling supported by my health care providers	1.59±1.05	1–5	0.44	0.94
23	Feeling like I am no longer able to mentally "fight" the challenges of my illness	1.78±1.18	1–5	0.74	0.94
24	Not being able to accept the way things are	2.01±1.34	1–5	0.71	0.94
25	Not being treated with respect or understanding by others	1.91±1.28	1–5	0.66	0.94
Total		48.58±21.11	25–125	–	0.94

Note: *Items modified.
Abbreviation: PDI, Patient Dignity Inventory

significantly correlated with the total score of the PDI: "suicide risk", "insufficient social and economic condition", "no need for supplementary laboratory and clinical tests" (Table 7). Applying the stepwise multiple linear regression model to the correlation between our three factors and other variables, we highlighted the following:

- Factor 1 was statistically significantly positively correlated with "suicide risk", "insufficient social and economic condition", "no need for supplementary laboratory and clinical tests", and with "the marital status of widowed/divorced".
- Factor 2 was statistically significantly negatively correlated with "absent outpatient service programs" and positively

Table 4 Initial factor loading for the PDI

Initial factors	Eigenvalues	Proportion	Cumulative
Factor 1	10.54	0.69	0.69
Factor 2	1.16	0.07	0.76
Factor 3	1.00	0.06	0.83
Factor 4	0.79	0.05	0.88
Factor 5	0.66	0.04	0.93
Factor 6	0.52	0.03	0.96
Factor 7	0.44	0.02	0.99
Factor 8	0.38	0.02	1.01
Factor 9	0.31	0.02	1.04
Factor 10	0.24	0.01	1.05

Note: The 10 largest initial eigenvalues of the 1–10 Factors are summarized.
Abbreviation: PDI, Patient Dignity Inventory.

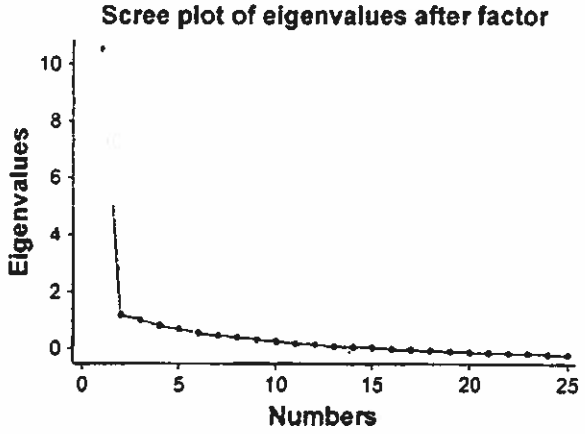

Figure 1 Scree plot of the factorial analysis.

Table 5 Rotated factor loadings and uniqueness in the PDI factorial analysis

Items		Factor 1 "loss of self-identity and anxiety for future"	Factor 2 "concerns for social dignity and spiritual life"	Factor 3 "loss of personal autonomy"	Uniqueness
1	Not being able to carry out tasks associated with daily living	0.18	0.15	0.84	0.24
2	Not being able to attend to my bodily functions independently	0.23	0.06	0.8	0.31
3	*Experiencing physically distressing symptoms as drug adverse effects*	*0.26*	*0.08*	*0.26*	*0.86*
4	Feeling that how I look to others has changed significantly	0.46	0.14	0.25	0.71
5	Feeling depressed	0.79	0.05	0.11	0.3
6	Feeling anxious	0.79	0.04	0.14	0.35
7	Feeling uncertain about my illness and treatment	0.6	0.31	0.29	0.45
8	Worrying about my future	0.66	0.19	0.11	0.5
9	Not being able to think clearly	0.44	0.44	0.49	0.38
10	*Not being able to continue with my usual routines*	*0.34*	*0.36*	*0.18*	*0.72*
11	Feeling like I am no longer who I was	0.51	0.38	0.16	0.57
12	Not feeling worthwhile or valued	0.57	0.33	0.22	0.51
13	Not being able to carry out important roles (eg, spouse, parent)	0.51	0.32	0.37	0.5
14	Feeling that life no longer has meaning or purpose	0.68	0.26	0.26	0.39
15	Feeling that I have not made a meaningful and lasting contribution during my lifetime	0.7	0.39	0.20	0.32
16	Feeling I have "unfinished business" (eg, things left unsaid or incomplete)	0.45	0.43	0.22	0.56
17	Concern that my spiritual life is not meaningful	0.24	0.59	0.00	0.6
18	Feeling that I am a burden to others	0.52	0.33	0.26	0.55
19	Feeling that I do not have control over my life	0.68	0.44	0.32	0.25
20	Feeling that my illness and care needs have reduced my privacy	0.31	0.55	0.14	0.58
21	Not feeling supported by my community of friends and family	0.22	0.63	0.21	0.51
22	Not feeling supported by my health care providers	0.15	0.42	0.22	0.75
23	Feeling like I am no longer able to mentally "fight" the challenges of my illness	0.66	0.38	0.17	0.39
24	Not being able to accept the way things are	0.67	0.21	0.29	0.42
25	Not being treated with respect or understanding by others	0.31	0.57	0.29	0.5

Note: The items excluded are in italics and the items loading factors are in bold.
Abbreviation: PDI, Patient Dignity Inventory.

with "insufficient social and economic condition" and "no need for supplementary laboratory and clinical tests".

- Factor 3 was statistically significantly positively correlated with "age", although with a low coefficient, and with "being hospitalized in psychiatry for the first time" (Table 7).

Discussion

Our research analyzed the psychometric properties of PDI, developed and validated for cancer patients, among patients hospitalized in a psychiatric ward. Although neoplastic diseases and mental disorders are pathologically very distant, both conditions can lead to drastic changes in patients'

Table 6 Correlations of PDI and three factors with scale scores

Scale	PDI (m=49.10±20.9 SD)	Factor 1 (m=31.01±14.65 SD)	Factor 2 (m=9.04±4.32 SD)	Factor 3 (m=4.84±2.85 SD)
GAF (mean±SD)				
71.67±15.04	NS	NS	NS	NS
Ham-D (mean±SD)				
14.54±8.13	Spearman's rho=0.3439 ($p<0.0001$)	Spearman's rho=0.3526 ($p<0.0001$)	Spearman's rho=0.2408 ($p=0.0049$)	Spearman's rho=0.2781 ($p=0.0011$)
Ham-A (mean±SD)				
10.44±7.91	Spearman's rho=0.3224 ($p<0.0001$)	Spearman's rho=0.3413 ($p=0.0001$)	Spearman's rho=0.2448 ($p=0.042$)	Spearman's rho=0.2059 ($p=0.0166$)
HoNOS at admission (mean±SD)				
24.99±8.45	NS	NS	NS	NS
HoNOS at discharge (mean±SD)				
17.80±6.8*	NS	NS	NS	NS

Notes: *HoNOS at admission vs HoNOS at discharge, $p<0.001$, $t=14.19$, paired t-test. Factor 1: "Loss of self-identity and anxiety for future"; Factor 2: "Concerns for social dignity and spiritual life"; Factor 3: "Loss of personal autonomy".
Abbreviations: GAF, Global Assessment of Functioning; Ham-A, Hamilton Anxiety Rating Scale; Ham-D, Hamilton Rating Scale for Depression; HoNOS, Health of the Nation Outcome Scales; PDI, Patient Dignity Inventory; NS, not significant.

Table 7 Variables related to PDI and Factors 1, 2, and 3 (stepwise multiple linear regression)

Variable* (reference category)	Coefficient	Standard error	95% CI	p-value
PDI score				
Social and economic conditions (sufficient)				
Insufficient	13.11	4.19	4.83 to 21.38	0.002
Suicidal risk (absent)				
Present	11.07	3.82	3.53 to 18.61	0.004
Need for clinical and instrumental test (present)				
Absent	7.99	3.12	1.83 to 14.15	0.011
Factor 1				
Social and economic conditions (sufficient)				
Insufficient	7.19	2.84	1.58 to 12.80	0.012
Suicidal risk (absent)				
Present	6.96	2.54	1.93 to 11.99	0.007
Need for clinical and instrumental test (present)				
Absent	4.77	1.99	0.83 to 8.70	0.018
Marital status (single)				
Divorced/widowed	5.55	2.73	0.16 to 10.94	0.044
Factor 2				
Social and economic conditions (sufficient)				
Insufficient	2.74	0.66	1.44 to 4.04	<0.001
Need for supplementary laboratory and clinical tests (present)				
No need	1.13	0.48	0.19 to 2.07	0.019
Outpatient service therapeutic-rehabilitative programs (present)				
Absent	−2.24	0.85	−3.91 to −0.56	0.009
Factor 3				
Age (years)	0.032	0.015	0.00 to 0.06	0.036
Number of previous psychiatric hospitalizations (one or more than one)				
First psychiatric hospitalization	1.12	0.45	0.24 to 2.01	0.013

Notes: *Only the statistically significant variables are reported. Factor 1: "Loss of self-identity and anxiety for future"; Factor 2: "Concerns for social dignity and spiritual life"; Factor 3: "Loss of personal autonomy".
Abbreviation: PDI, Patient Dignity Inventory.

lives, with high risk of loss of dignity. Both pathologies are often chronic and require long-term therapies and recurrent admissions for exacerbations and/or complications. In addition, the hospitalization, by itself, can induce a further risk of behavioral regression, as many researchers have pointed out.[51–53]

The patients in our sample, although suffering from severe and chronic diseases, showed good response rate (93%), suggesting that the questionnaire was easy to understand as well as to fill in. Its content aroused great interest among patients, who showed a clear understanding of the meaning of dignity. Administering the PDI close to discharge may have enhanced acceptance, given that patients clinically and functionally improved as evidenced by the HoNOS and GAF scale scores, respectively.

The present study confirms our preliminary validation results and all previous studies in many different settings,[18–19,21] suggesting the universality of the dignity theme in health care contexts and the reliability of the PDI questionnaire in detecting this dimension of patient experience. Similar to our previous study, this second factorial analysis showed that dignity is shaped by three dimensions that account for >80% of the variance. This result, which suggests that more than one existential, psychological, and/or social dimension can influence the perception of dignity, is consistent with all other validation studies,[24,30–33] with the exception of the first Italian validation study,[28] which identified only one factor. In particular, Factor 1, "loss of self-identity and anxiety for the future", consisted of the greatest number of items with the highest internal consistency. It included items related to maintaining self-identity and items that investigate anxiety and uncertainty for future (items 4, 5, 6, 7, and 11). Our three factors loaded all items except two: items 3 and 10. This result confirms the lack of specificity of item no. 3, relating to the physical complications of the disease (which we changed to "tolerate drug side effects"), probably because somatic symptoms among psychiatric diseases do not constitute a therapeutic priority, although they may be a comorbidity. In contrast to the preliminary study, item 10, "not being able to continue the usual activities", did not load

any factor in this extension study. We can hypothesize that the lack of routine daily activities differs in some qualitative way from that experienced by terminally ill patients.

Our three-factor model largely overlaps with the three major dignity categories identified by Chochinov et al.[24] Moreover, our factorial analysis is consistent with Jacobson's notion of the "human and social" dimensions of dignity, which is formed by the interaction between individuals and society, with its culture and traditions.[54]

In our sample, Factor 1 obtained the highest score, indicating that the individual's dignity can be one of the most difficult ethical and psychological dimensions to preserve when an individual is suffering from a severe psychiatric disease. The data appear understandable in light of the fact that our sample consisted of patients hospitalized in acute psychiatric crisis: for about one-third of them, this was a first hospitalization experience and 47% had been admitted in a compulsory state. The experience of hospitalization, especially in a psychiatric environment, can represent a dramatic break from previous living conditions, as noted by many authors.[22,52,53] This condition can make the individual more vulnerable, undermining the sense of self and, at the same time, fostering feelings of anxiety and depression. Especially in an acute psychiatric ward, the limitation of living space, although often necessary to contain the most serious pathologies, deprives patients of liberty and privacy.

In our sample, the PDI score was significantly associated with the Hamilton scales for depression and anxiety, suggesting that the PDI maps well onto dimensions of depression and anxiety. This and the preliminary study results provide concurrent validity to the PDI applied in psychiatry setting. It should be emphasized that under severe anxiety and depression, patients show more marked problems in perception of dignity, as evidenced by Rullàn et al[30] who reported high scores in PDI among patients with anxious depressive disorders. Nevertheless, we can infer that these symptoms were related not only to a specific psychiatric diagnosis (most of our patients suffered from different kinds of diseases), but also to the hospitalization, which can induce anxiety and depressive feelings. As patients' self-perception of dignity is an important treatment goal to maintain during therapeutic work, clinicians would likely benefit from the findings in the current study, where the PDI was found to be a valid and reliable assessment tool.

Only a few variables were statistically significantly related to the PDI score in our multiple linear regression model, in particular "insufficient social and economic condition" among demographic variables, "suicide risk" and "no need for supplementary laboratory and clinical tests", among clinical ones. This result suggests that dignity among patients hospitalized in psychiatry can be undermined by both clinical and social factors. In particular, feelings of uncertainty for precarious economic conditions as well as feelings of hopelessness and helplessness associated with suicidal thoughts can be strong detrimental factors for dignity preservation. The association between the "no need for supplementary laboratory and clinical examinations" and the risk of compromised dignity could indicate that psychiatric illness alone can represent a risk of loss of dignity, even without organic comorbidity, probably for psychological suffering, social maladjustment, and stigma.

The statistically significant correlations between our three factors and variables further suggest the weight of this association and, at the same time, the specificity of the psychological dimensions that support the three factors. Factor 1 was statistically significantly associated not only with the three abovementioned variables, but also with the demographic variable "being widowed or divorced", a condition which can strongly damage the dignity of self-identity under vulnerable condition of illness, due to solitude and feelings of abandonment. Factor 2, "concerns for social dignity and spiritual life", was further confirmed by the statistically significant correlation with "insufficient social and economic condition". The risk of losing dignity in case of reduced independence level, identified by Factor 3, "loss of personal autonomy", was related to the increase in age, which is consistent with the literature,[55] and to the first psychiatric hospitalization experience, which can represent a dramatic disruption in life habits and expectations.[20,21]

Our survey confirmed that PDI is an easily understood and applied tool, regardless of the level of education, useful to quantify the subjective experience of dignity during hospitalization, as recently highlighted by some authors,[56] also in a psychiatric setting. The questionnaire, given in the days preceding discharge, can help professionals reflect on the care they have offered and its impact. At the same time, the PDI permits a better understanding of how patients experience illness and care, promoting a more empathetic therapeutic relationship. PDI administration was appreciated by our patients, who interpreted it as a sign of professional interest in them, which represents the foundation of all therapeutic approaches and conditions necessary for positive outcomes.[57]

Limitations

This study presents many limitations regarding settings, sample size, and the wide variety of diseases suffered by

our patients. The relatively small increase in sample size of this study, which is an extension of the preliminary validation research, is a particular limitation. Another problematic issue throughout the study is the limited generalizability of the findings, as the sample consisted of a cohort of Italian patients hospitalized in an inpatient psychiatric setting.

Conclusion

This extension study replicates previous preliminary results and adds new information regarding the variables that can influence the perception of dignity in a psychiatric setting: the clinical and social conditions of greatest seriousness, such as risk of suicide as well as social and economic disadvantage, can be factors closely related to loss of dignity among patients hospitalized in a psychiatric ward.

In the light of our findings, we conclude by saying that the PDI can be a reliable and valuable tool for discovering the subjective experience of dignity among patients hospitalized in a psychiatric ward, helping us to understand the various universal psychological dimensions that contribute to shape it: the area of the self, the social role, and the level of independence.

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Author contributions

All authors contributed toward data analysis, drafting and revising the paper and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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ORIGINAL CONTRIBUTION

Environmental changes to reduce self-harm on an adolescent inpatient psychiatric ward: an interrupted time series analysis

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Abstract
Existing interventions to reduce self-harm in adolescents admitted to psychiatric wards are usually focused on individual psychological treatments. However, the immediate ward environment in which treatment takes place is an important factor in the success of the treatment and can also influence the likelihood of self-harming behaviours. The aim of the current study was to evaluate changes made to a psychiatric ward environment on incidence of self-harm in adolescents. A quasi-experimental interrupted time series study was conducted on one child and adolescent psychiatric ward. An intervention was developed alongside staff and patients to address the high incidence of self-harm on weekday evenings on the ward. The intervention components involved adding a regular twilight shift (3–11 pm) for nursing staff and introducing a structured evening activity programme on the ward. A segmented regression analysis of an interrupted time series found that the rate of self-harm per 100 bed days was already declining at baseline and continued to decline post-intervention, but the rate of decline was not significant ($p = 0.415$). However, the proportion of patients self-harming was increasing at baseline and significantly reduced post-intervention ($p = 0.001$), and this reduction was significantly larger in the evenings ($p = 0.004$) compared to other times of day ($p = 0.09$). A tailored intervention targeting the psychiatric ward environment helped to reduce the proportion of adolescents self-harming on the ward. An interrupted time series analysis should be considered for future interventions making changes to health systems over time.

Keywords Self-harm · Inpatient · Mental health · Adolescent · Children · Psychiatry

Introduction

Self-harm, also referred to as deliberate self-harm, describes the action of intentionally injuring or poisoning oneself regardless of motivation or suicidal intent [1, 2]. Functions that may motivate or reinforce non-suicidal self-harming behaviour are self-punishment and avoidance of negative emotions [3–6]. Other functions of self-harm have also been identified such as interpersonal influence (to seek help from others) and peer bonding (fitting in with others), as well as sensation-seeking (seeking excitement, anti-dissociation) and gratification (self-harming as comforting) [3, 4]. Functions of self-harm with suicidal intent also include many functions associated with non-suicidal self-harm behaviour, in particular coping with self-hatred and sensation seeking [7]. These functions are exhibited in adolescents, and when combined with factors such as impulsivity and exposure to

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others who self-harm, can translate into self-harming behaviour with or without suicidal intent in the younger population [1, 8].

Adolescents with complex mental health needs and who are at serious risk of harming themselves or others may be supported in the community in services such as intensive home treatments and specialist outpatient settings [9–11]. However, some of these patients will be admitted for care in inpatient psychiatric wards [11, 12]. Around 10–20% of adolescents on inpatient wards will self-harm at least once during their stay, and a proportion of these will self-harm repeatedly as many as 130 times [13–16]. Longer duration on an inpatient ward is also predictive of more self-harm incidents in adolescents, and therefore, it is essential that adolescents should be supported in this setting [14]. Self-harm can have a damaging physical and psychological impact on the young person harming and also negatively impacts others who encounter the incident on a psychiatric ward. Clinicians on adolescent psychiatric wards report feeling distressed when attempting to de-escalate a self-harm attempt [17], in particular if using a restrictive practice [18–20]. Other adolescents on the ward are often distressed and influenced by self-harming behaviour and must find ways to cope with these feelings [21, 22]. Reducing self-harm on adolescent psychiatric wards is necessary to improve the well-being of the young person who self-harms, as well as other patients and clinicians present in this secure environment.

Risk factors of self-harm on inpatient psychiatric wards

Many adolescents on inpatient psychiatric wards have a previous history of self-harm. The risk factors of self-harm with both non-suicidal and suicidal intent are complex and include age, gender, mental health diagnosis, coping strategies, previous self-harm, acute stress response, relationship with family and friends, as well as social deprivation [7, 23–27]. The likelihood of self-harm is also influenced by more immediate contextual factors such as social influences and the environment of care on inpatient psychiatric wards [12, 23, 28, 29].

Young people may be inclined to self-harm by mimicking self-harming behaviours in others [1]. This is of particular concern on inpatient psychiatric units, where young people are in close proximity to others who self-harm [15, 30, 31]. However, such contagion effects are only one possible environmental influence. A combination of loneliness, isolation from others and a lack of stimulation can further contribute to self-harming behaviours of inpatients on psychiatric wards [22, 32]. This is likely due to an increase in negative emotions in an individual, as well as the positive functions of self-harm which can provide comfort and excitement during this period [4]. This is apparent on adult psychiatric wards, where self-harming behaviours commonly occur when patients are alone in the evening [32–34] and on private areas like the bedroom and bathroom [32, 33]. Young people in the community also report more self-harming thoughts when they are alone [35] and usually consider self-harm a private act, to be done in secrecy [36]. The social relationship between adolescents and nursing staff on psychiatric wards can also influence self-harming behaviours, as young people reportedly harm less when nursing staff intervened during early warning signs of distress [28]. As indicated by the interpersonal function of self-harm, it is possible that patients may use self-harming behaviour to seek help when they do not feel supported by nursing staff on wards [3, 5]. Other contextual factors such as interaction with other inpatients, ward rules and routines, length of stay on the ward, amount of leave granted, voluntary or involuntary admission, and the general ward atmosphere are also likely to contribute to self-harming behaviours in adolescents admitted on inpatient psychiatric wards [12, 23, 28].

Interventions to reduce adolescent self-harm on wards

Therapeutic approaches such as dialectical behaviour therapy (DBT) and cognitive behaviour therapy (CBT) are commonly used to treat adolescents who self-harm with and without suicidal intent. DBT is a highly structured psychotherapy delivered in individual sessions and in groups to help patients regulate their emotions and equip them with the skills to tolerate distress, practice mindfulness and reduce maladaptive behaviours such as self-harm [37, 38]. CBT similarly helps patients to regulate their emotions by modifying distorted thinking patterns and strengthening coping, communication and problem solving skills [39, 40]. DBT and CBT have been adapted and implemented within inpatient settings and have reduced self-harming behaviours in adolescents [37, 39–43]. However, the ward environment also plays a key role in the success of these treatments and can actively contribute to self-harming behaviours in adolescents [12, 23, 28, 29]. Safety analysis in other areas of healthcare, and in other industries, also suggest that wider organisational and environmental factors are important contributory factors to safety incidents [44]. Thus, interventions to reduce self-harm in adolescents should not just treat the young person but consider improving the immediate psychiatric ward environment for adolescents being cared for in this setting.

A small number of interventions have combined therapeutic interventions with environmental changes on the ward to reduce self-harming behaviour. In one study, adolescent inpatients were exposed to either normal DBT training, DBT-based environmental changes or both [45]. The environmental changes included analysing problematic behaviour in patients and behavioural interventions [45]. However, only non-suicidal self-harm incidents were monitored in this

study and the effects on self-harm were unclear due to high levels of attrition [45]. More recently, adolescent inpatients were given extensive DBT skills training as well as being introduced to daily leisure activities on the ward such as pet therapy and pottery making [46]. The intervention was successful in reducing both suicidal and non-suicidal self-harm when compared to adolescents treated as usual, but the influence of activities as an environmental change on self-harm was unclear [46]. Meaningful activities have often been suggested as a possible way to distract inpatients who may self-harm on an inpatient setting [33, 36, 47] as distraction can help adolescents cope with distress when alone [6, 34, 48]. It is also possible that meaningful activities can serve to replace the positive functions associated with both non-suicidal and suicidal self-harm, such as feelings of gratification and sensation seeking [4]. This needs to be examined further on inpatient settings.

Other interventions have made changes to only the psychiatric ward environment to reduce self-harm in patients on the ward. One study found that employing an additional nurse to improve communication between staff and inpatients and ensure an ethical approach to rules and routines helped reduce harmful patient behaviours including self-harm [49]. Another intervention, consisting of ten best practices for staff to communicate with inpatients, also showed a significant reduction in self-harming behaviours [50]. However, these and other similar interventions have been conducted on adult inpatient settings [49–51] and have not always been replicated [52]. A much larger intervention conducted over 5 years on an adolescent psychiatric unit significantly reduced self-harm by training staff to improve communication with adolescents on the ward and by improving responses to maladaptive patient behaviours [53]. Staff training and better responses to harmful patient incidents was also found to be effective in reducing aggressive incidents in adolescents on a psychiatric ward, including aggression towards themselves [54]. While these interventions are very important in the longer term care of patients, they do not offer immediate improvements to the ward environment to reduce self-harm in adolescents.

Environmental changes that do successfully reduce self-harm for both adults and adolescents admitted on a psychiatric ward have generally been analysed using a simple pre–post analysis [49, 50, 54]. This analysis does not take into account the longitudinal nature of these changes nor does it consider any pre-intervention trends; for instance, if harmful incidents were reducing before the intervention then a pre–post analysis could show a significant decrease in incidents even when this does not actually exist (i.e., a type 1 error). An interrupted time series analysis is an alternative approach which takes into account both the longitudinal data and pre-intervention trends and should be considered when evaluating health system interventions over time [55, 56].

Objective

The current intervention was designed to improve an adolescent psychiatric ward environment with input from staff and patients on the ward. The aim of the intervention was to (i) reduce the rate of self-harm incidents and (ii) reduce the proportion of adolescents self-harming on the ward, by rigorously evaluating the intervention using an interrupted time series analysis.

Methods

Study design

A quasi-experimental design using an interrupted time series analysis was conducted to evaluate an intervention that made changes to the psychiatric ward environment. The baseline period was 1st June 2016 to 31st May 2018 and the intervention was introduced on 1st June 2018. Outcome data post-intervention was collected for 18 months. The study was primarily aimed at improving a healthcare service, and therefore, a formal research ethics application was not required.

Setting and participants

The study was carried out on one child and adolescent psychiatry inpatient ward in the UK for children aged between 12 and 18 years. The ward has 12 inpatient beds and has a school for patients on the ward to attend in the day. Visiting hours on the ward are usually between 4.30 and 8.30 pm in the evenings and many inpatients are also given leave from Friday evening to Sunday evening to be at home with their families.

Group therapy sessions happen daily between 2 and 3 pm, with some occasional activities in the evenings. Individual treatment sessions usually consist of weekly meetings with an assigned key nurse, psychiatrist and psychology sessions as needed. Patients with emotional dysregulation also attend the 'managing emotions' pathway, consisting of individual skill learning and weekly group sessions. Medication is provided to patients based on clinical need and within dose recommendations by the British National Formulary. This includes antidepressants as clinically required for depression, anxiety, panic or PTSD, low dose antipsychotic sometimes prescribed for agitation, and a low dose benzodiazepine during de-escalation, only if not possible to de-escalate with good nursing care, distraction or reinforcing of coping skills. Rapid tranquisalisation is rarely used on the ward.

The ward has a multidisciplinary team of staff who support the care of inpatients, including: 1 full time equivalent consultant psychiatrist, 2 trainee doctors, 0.6 speciality

doctor, 0.8 family therapist, 0.5 social worker, 1 clinical psychologist, 1 assistant psychologist and 1.2 occupational therapists. Prior to the intervention, the regular shift patterns for nursing staff on the ward were early (7 am–2.45 pm), late (1.15 pm–9 pm) and night (8.40 pm–7.20 am), with 7 nurses on the ward during early/late and 5 nurses at night. An ad-hoc twilight shift (3–11 pm) was introduced on some evenings at short notice when the ward was considered unstable, and these would often be covered by expensive temporary nursing staff.

Intervention

The intervention was co-designed with clinical ward staff with regular input from patients to reduce self-harm on the ward. The experiences of clinical staff and routinely collected self-harm data on the ward highlighted a clear temporal tend; 62% of self-harm incidents occurred between 5 pm and 11 pm over a year. With this insight, an intervention was designed to focus on the vulnerable evening period on the ward. Iterative changes were made to the intervention following feedback from staff and patients, but the main intervention components did not change.

Regular twilight shifts

The first component of the intervention was introducing a regular twilight shift for nursing staff (3 pm–11 pm, Sunday–Thursday) to provide additional support on the ward during the vulnerable evening period and during the transition of late shift to night shift staff. The regular twilight shifts were introduced from 1st June 2018. Although self-harm incidents on the ward were highest between 5 and 11 pm, the twilight shifts were kept at 8 h to comply with NHS guidelines. No twilight shifts were added on Fridays and Saturdays as many inpatients take leave from Friday evenings to Sunday afternoon. The intervention component was designed to increase availability of regular nursing staff on the ward during a vulnerable time, rather than employing expensive temporary agency staff. Although cost and travel implications made it challenging for regular nursing staff to take these shifts when first introduced, over time there was a gradual decrease of temporary staff being used on the ward as twilight shifts began to be filled by regular nursing staff (see Appendix Table A.1).

Evening activities

The second component of the intervention was a structured programme of evening activities. The evening activities were introduced gradually on the ward from 1st July 2018 with a complete programme available from 1st September 2018. These activities were not intended to be directly therapeutic, but simply normal activities for young people to take part in during less structured times of the day. All activities were voluntary. The attendance for each evening activity was not recorded. However, staff on this small inpatient unit made every effort to invite all patients to attend evening activities, and attendance was high at most activities. All patients on the ward attended evening activities during the course of their stay if they were well enough to join. Patients were encouraged to suggest activities they would like, and activities offered in the evening changed regularly to reflect their feedback. Activities included a games and drama workshop (e.g., role-playing and storytelling), visits from a Pets As Therapy (PAT) dog, mindfulness podcast groups, and an art and coping skills workshop (e.g., drawing, painting and pottery), conducted by activity workers or occupational therapists on the ward (see Table 1).

Measures

Outcome measures were collected through routinely available data in the healthcare organisation. All data used in this study is routinely reported by clinical staff on the inpatient psychiatric ward through an incident reporting system. The data reported will include detailed information about the incident, such as the type of self-harm, the patient and staff involved, the harm to the patient or others, measures used to contain the self-harm and a narrative summary of the incident. The incident report is subsequently checked by the matron of the inpatient psychiatric ward, the system administrator of the incident reporting database, and the clinical lead for the organisation who is responsible for producing quarterly reports on self-harm as well as other major incidents. Although the clinical staff and the matron were not blinded to the intervention, other parties responsible for checking the data were not aware of when the intervention was happening on the ward. There was no change to routine data-reporting pre- and post-intervention.

The primary outcome measures were rate of self-harm per 100 bed days and the proportion of patients

Table 1 Example of a structured evening activity programme on the ward

Evenings	Activity offered
Monday	Mindfulness podcast
Tuesday	Art and coping skills; mindfulness podcast*
Wednesday	PAT dog visit; mindfulness podcast*
Thursday	Games and drama workshop; mindfulness podcast*

All activities were an hour long and took place before and after evening dinner (between 5 and 9 pm)

PAT pets as therapy

*Patients could choose to attend either of the two activities offered

self-harming. Self-harm was defined as intentional self-poisoning or injury, irrespective of whether the act was intended as suicidal or non-suicidal. All types of self-harm were included, such as poisoning, asphyxiation, cutting, burning and other self-inflicted injuries. This definition was in line with the national guidance on how self-harm incidents should be recorded by healthcare organisations.

Rate of self-harm incidents per 100 bed days

Monthly number of self-harm incidents on the ward were collated between 1st June 2016 and 31st November 2019. A standardised self-harm rate per 100 occupied bed days was calculated (i.e., the number of self-harm incidents that occurred for every 100 days an inpatient was on the ward). This is a recommended method to report incidents as it takes into consideration the varying lengths of stay by patients and can also be easily compared to incidents on other wards [57]. The psychiatric ward in this study had an average bed occupancy rate of 75.5% between November 2017 and November 2019 (bed occupancy rate prior to these dates was not easily available). To calculate the rate of self-harm in June 2016 as an example, the number of incidents that occurred during this month was divided by the number of beds available that month ((12 beds × 30 days) × 75.5%), and then multiplied by 100. Monthly rates of self-harm per 100 occupied bed days was calculated overall and was also spilt by time of day to determine whether the reduction of self-harm was larger in the evening compared to other times of the day. For the purpose of this study, evening referred to 3–11 pm (to align with the twilight shift hours) and non-evening was any time of day excluding 3–11 pm.

Proportion of patients self-harming

The overall rate of self-harm is important but may be unduly influenced by a small number of people who self-harm very frequently [57]. From a therapeutic standpoint it is arguably even more important to reduce the number of people who self-harm. The number of patients self-harming on the ward each month were collated between 1st June 2016 and 31st November 2019. This was divided by the total number of patients that were admitted on the ward that month, and then multiplied by 100 to obtain the percentage of patients self-harming. This is a standardised measure that takes into account the different number of patients present on inpatient wards and can be compared across inpatient services [33, 57]. As well as the total proportion, the proportion of patients self-harming in the evening and non-evening period was also calculated.

Patient characteristics and diagnosis

Patient characteristics and clinical diagnosis were obtained from the hospital episodes statistics database from the healthcare organisation. Patient diagnosis was based on a full clinical assessment conducted by a consultant psychiatrist. These clinical assessments are based on the ICD-10 criteria [58], the clinical judgment of the psychiatrist and discussions with the patient and their family. When clinically indicated, the diagnosis for mental health patients is clearly described to patients and families, including for patients with emotionally unstable personality disorder. However, in cases when the symptomatology remains unclear, the diagnosis will be tentative and subject to review.

Statistical analysis

Patient characteristics at baseline and post-intervention were analysed for differences using an ANOVA and Chi square analysis. A segmented regression analysis of an interrupted time series was conducted to compare monthly data on rate of self-harm and proportion of patients self-harming before and after the intervention was introduced, as recommended by previous studies [55, 56, 59–61]. The analysis was done for a 2-year baseline period (1st June 2016 to 31st May 2018) and 18-month post-intervention (1st June 2018 to 31st November 2019). It was expected that the intervention would have a gradual impact on the outcome of self-harm, and therefore, only the change in slope was analysed at baseline compared to post-intervention over time [55, 60].

All data was analysed using R software [62]. A Poisson regression model was used to analyse the rate of self-harm per 100 bed days by including the count of all self-harm incidents as a dependent variable in the model and the occupied bed days as an offset term. A Binomial regression model was used to analyse the proportion of patients self-harming. Autocorrelation in the data was assessed by examining the partial autocorrelation function and by conducting the Breusch–Godfrey test [63]. Autocorrelation refers to any significant correlation between data reported at one time point with subsequent time points (i.e., 1 month with any subsequent months). A significant correlation between every 12 months would indicate seasonality in the dataset. Minimal autocorrelation was identified for findings that were significant pre and post-intervention. Therefore, no adjustments for autocorrelation to these models were required. The counterfactual scenario, or the assumption that the pre-intervention trend would have continued unchanged if there was no intervention, was also computed. Two patients that self-harmed extensively (> 3.5 standard deviations over the mean self-harm incidents per person) were considered outliers in the study. Segmented regression analysis was conducted without the outliers and with the outliers included.

Results

Participants

A total of 205 young people were hospitalised for psychiatric care on one UK adolescent psychiatric ward between 1st June 2016 and 31st November 2019. Patients ranged from 12 to 18 years, and mean age was 15.65 years (SD 1.48). Average length of stay was 75.27 days (SD 72.27) and ranged from 0 to 406 days. The majority of patients were female ($n=175$, 85.37%) and the remaining patients were male ($n=29$, 14.15%) or did not specify their gender ($n=1$, 0.49%). The most common primary mental health diagnosis was eating disorders ($n=87$, 42.44%). Only 6 patients had an unspecified mental health disorder (2.92%).

There were 124 patients on the psychiatric ward before the intervention was implemented (1st June 2016 to 31st May 2018) and 71 patients after implementation (1st June 2018 to 31st November 2019). A further 10 patients remained on the psychiatric ward both before and after the intervention was introduced (see Table 2). There was no significant difference in age ($F=2.29$, $p>0.05$) and gender ($x^2=7.84$, $p>0.05$) between patients in either groups.

Impact of intervention on rate of self-harm

The average rate of self-harm per 100 bed days per month shows that self-harm incidents reduced post-intervention compared to baseline (see Table 3). When split by time of day, the average rate of self-harm per month also showed a reduction both in the evening and non-evening period following the intervention compared to baseline.

A segmented regression analysis for monthly rates of self-harm per 100 bed days without outliers showed that the rate of self-harm was steadily declining before the intervention was implemented, but the rate of decline was not significantly affected by the intervention (see Fig. 1; change in slope – 0.01, 95% CI – 0.04 to 0.02, $p=0.415$). When split by time of day, the rate of self-harm was declining in the evening and non-evening period before the intervention and again the decline was not significantly affected by the intervention (see Fig. 2; Evening: change in slope – 0.007,

Table 2 Patient characteristics pre- and post-intervention

	Pre-intervention ($n=124$)	Post-intervention ($n=71$)	Pre- and post-intervention ($n=10$)
Age, years			
Mean ± SD	15.81 ± 1.41	15.35 ± 1.60	15.90 ± 1.29
Range	12–18	12–18	14–18
Gender (n, %)			
Male	17 (13.7%)	8 (11.3%)	4 (40%)
Female	107 (86.3%)	62 (87.3%)	6 (60%)
Not specified	0	1 (1.4%)	0
Length of stay, days			
Mean ± SD	64.29 ± 65.07	81.97 ± 67.51	163.80 ± 119.77
Range	0–328	5–298	62–406
Primary diagnosis (n, %)			
Adjustment and dissociative	6 (4.8%)	2 (2.8%)	0
Anxiety	11 (8.9%)	7 (9.9%)	0
Developmental	3 (2.4%)	2 (2.8%)	1 (10%)
Eating	46 (37.1%)	35 (49.3%)	6 (60%)
Mood	19 (15.3%)	9 (12.7%)	0
Obsessive compulsive	1 (0.8%)	1 (1.4%)	1 (10%)
Other	9 (7.3%)	5 (7.0%)	1 (10%)
Personality	8 (6.5%)	4 (5.6%)	0
Phobias	1 (0.8%)	0	1 (10%)
Schizophrenia and psychosis	9 (7.3%)	2 (2.8%)	0
Stress-related	2 (1.6%)	1 (1.4%)	0
Substance abuse	3 (2.4%)	1 (1.4%)	0
Unknown	5 (4.0%)	1 (1.4%)	0

Pre-intervention dates: 1st June 2016 to 31st May 2018; Post-intervention dates: 1st June 2018 to 31st November 2019; Pre- and post-intervention dates: 1st June 2016 to 31st November 2019

Table 3 Rate of self-harm per 100 bed days per month pre- and post-intervention, without outliers

	Self-harm incidents, total		Self-harm incidents, evening		Self-harm incidents, non-evening	
	Mean (SD)	Range	Mean (SD)	Range	Mean (SD)	Range
Pre-intervention	5.49 (3.47)	1.07–13.61	3.58 (2.36)	1.07–9.20	1.91 (1.34)	0–4.42
Post-intervention	3.23 (2.27)	0–9.20	2.21 (1.81)	0–7	1.02 (0.93)	0–2.94

Pre-intervention dates: 1st June 2016 to 31st May 2018; Post-intervention dates: 1st June 2018 to 31st November 2019; Evening = 3–11 pm; Non-evening = any time excluding 3–11 pm

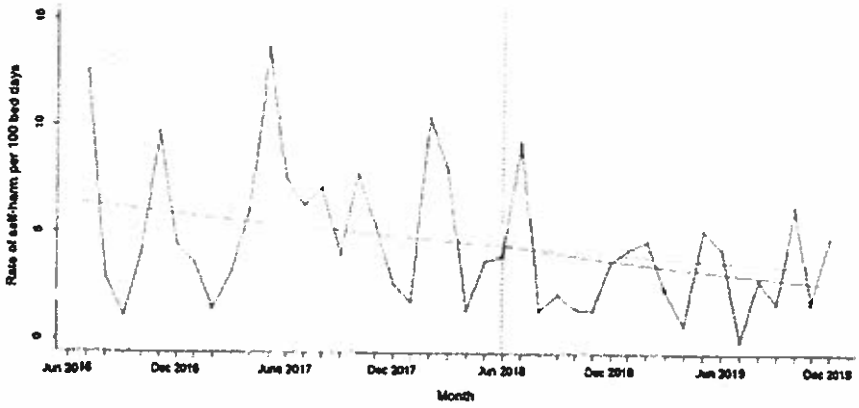

Fig. 1 Rate of self-harm per 100 bed days at baseline and post intervention. The figure shows the monthly rate of self-harm between 1st June 2016 and 31st November 2019 after removing outliers. The intervention was introduced on 1st June 2018 indicated by the vertical line. The solid red line indicates the segmented regression analysis conducted at baseline and at post-intervention. The red dashed line indicates the counterfactual scenario (i.e. projected rate of self-harm if the intervention had not been conducted)

95% CI − 0.05 to 0.03, $p = 0.676$; Non-evening: change in slope − 0.02, 95% CI − 0.07 to 0.03, $p = 0.414$). This analysis shows that while the rate of self-harm continued to decline on the psychiatric ward after the intervention was introduced, this was not significantly affected by the evening-based interventions.

When outliers were included in the analysis, the monthly rates of self-harm per 100 bed days was also steadily declining before the intervention but the rate of self-harm significantly increased following the intervention (change in slope: 0.09, 95% CI 0.07–0.11, $p < 0.0001$). When split by time of day, the rate of self-harm was declining in the evening and non-evening period before the intervention and again the rate significantly increased following the intervention (Evening: change in slope 0.09, 95% CI 0.06–0.12, $p < 0.001$; Non-evening: change in slope 0.08, 95% CI 0.04 to 0.12, $p < 0.001$). This indicates that the rates of self-harm increased post-intervention mostly due to two patients who self-harmed frequently.

Impact of intervention on proportion of patients self-harming

The average proportion of patients self-harming per month reduced post-intervention compared to baseline (see Table 4). When split by time of day, the average proportion of patients self-harming also reduced both in the evening and non-evening period following the intervention compared to baseline.

A segmented regression analysis without outliers showed that the proportion of patients self-harming was increasing before the intervention and significantly reduced following intervention (see Fig. 3; change in slope − 0.18, 95% CI − 0.16 to − 0.04, $p = 0.001$). When split by time of day, the proportion of patients self-harming per month was also increasing in the evening period before the intervention and significantly reduced after the intervention was introduced (see Fig. 4; change in slope − 0.09, 95% CI − 0.16 to − 0.03, $p = 0.004$). The proportion of patients self-harming per month in the non-evening period was also increasing before the intervention and reduced after the intervention was introduced, but the rate of decline was not significant (change in slope − 0.06, 95% CI − 0.15 to 0.01, $p = 0.09$). This analysis shows that the proportion of patients self-harming

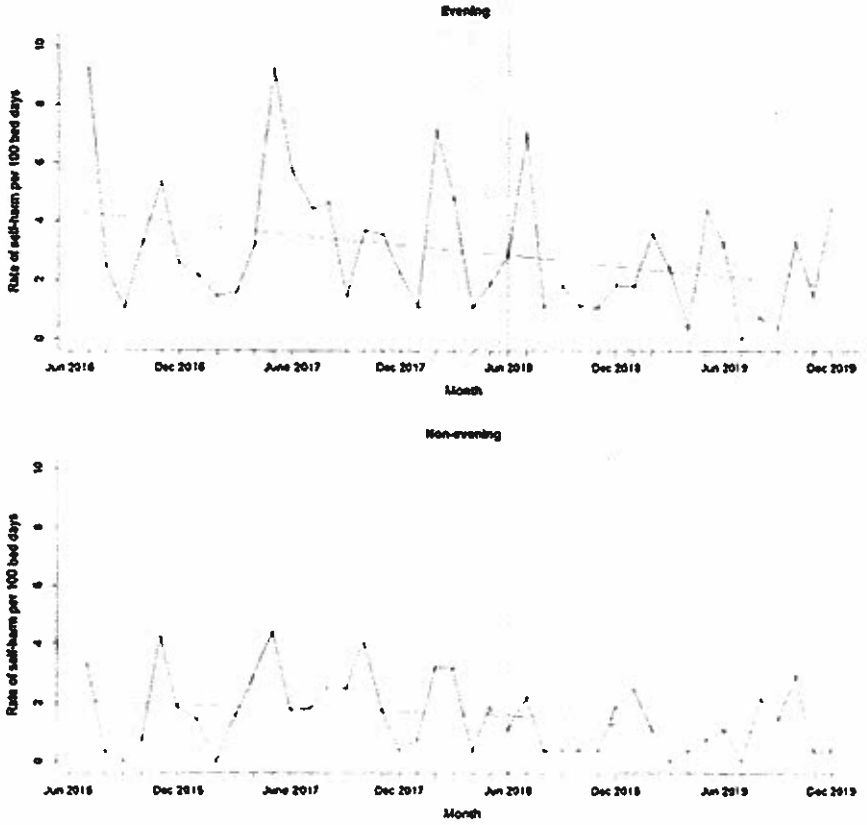

Fig. 2 Rate of self-harm per 100 bed days at baseline and post intervention split by evening (3–11pm) and non-evening period. The figure shows the monthly rate of self-harm between 1st June 2016 and 31st November 2019 after removing outliers, split by time of day. Evening refers to 3-11pm and non-evening period refers to any time of day excluding 3-11pm. The intervention was introduced on 1st June 2018 indicated by the vertical line. The solid red line indicates the segmented regression analysis conducted at baseline and at post-intervention. The red dashed line indicates the counterfactual scenario (i.e. projected rate of self-harm if the intervention had not been conducted)

Table 4 Proportion of patients self-harming per month pre- and post-intervention, without outliers

	Patients self-harming, total		Patients self-harming, evening		Patients self-harming, non-evening	
	Mean (SD)	Range	Mean (SD)	Range	Mean (SD)	Range
Pre-intervention	33.09 (13.94)	12.50–73.33	26.50 (11.46)	6.67–60.00	17.81 (11.59)	0–46.67
Post-intervention	20.35 (20.35)	0–40.00	17.19 (10.11)	0–33.33	8.69 (6.27)	0–26.67

Pre-intervention dates: 1st June 2016 to 31st May 2018; Post-intervention dates: 1st June 2018 to 31st November 2019; Evening = 3–11 pm; Non-evening = any time excluding 3–11 pm

significantly reduced after the intervention was introduced, and this effect was driven primarily by a significant reduction in the evening.

When outliers were included in the analysis, the proportion of patients self-harming per month was increasing before the intervention but significantly reduced following intervention (change in slope: – 0.06, 95% CI – 0.13 to – 0.01, $p = 0.021$). The proportion of patients self-harming per month in the evening was also increasing before the intervention and reduced after the intervention was introduced, but this was trending at significance (change in slope: – 0.06, 95% CI – 0.12 to 0.001, $p = 0.054$). The proportion of patients self-harming in the non-evening period also increased before the intervention and reduced after the intervention was introduced, but the rate of decline was not significant (change in slope: – 0.01, 95% CI – 0.09 to 0.06, $p = 0.704$). This indicates that even with the two outlier patients included, the proportion of people self-harming reduced post-intervention and this was driven by a reduction in the evening.

Discussion

The current study evaluated an intervention that made immediate changes to an adolescent psychiatric inpatient environment to reduce self-harming behaviours with and without suicidal intent. Evenings were identified as a peak time for

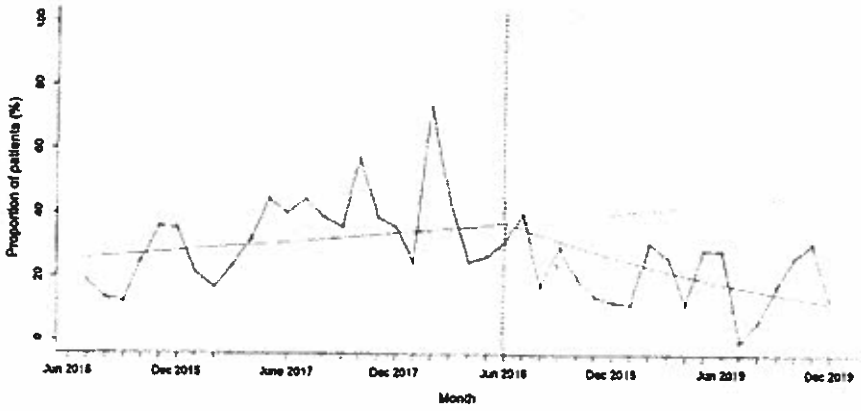

Fig. 3 Proportion of patients self-harming at baseline and post intervention. The figure shows the proportion of patients self-harming per month between 1st June 2016 and 31st November 2019 after removing outliers. The intervention was introduced on 1st June 2018 indicated by the vertical line. The solid red line indicates the segmented regression analysis conducted at baseline and at post-intervention. The red dashed line indicates the counterfactual scenario (i.e. projected proportion of patients self-harming if the intervention had not been conducted)

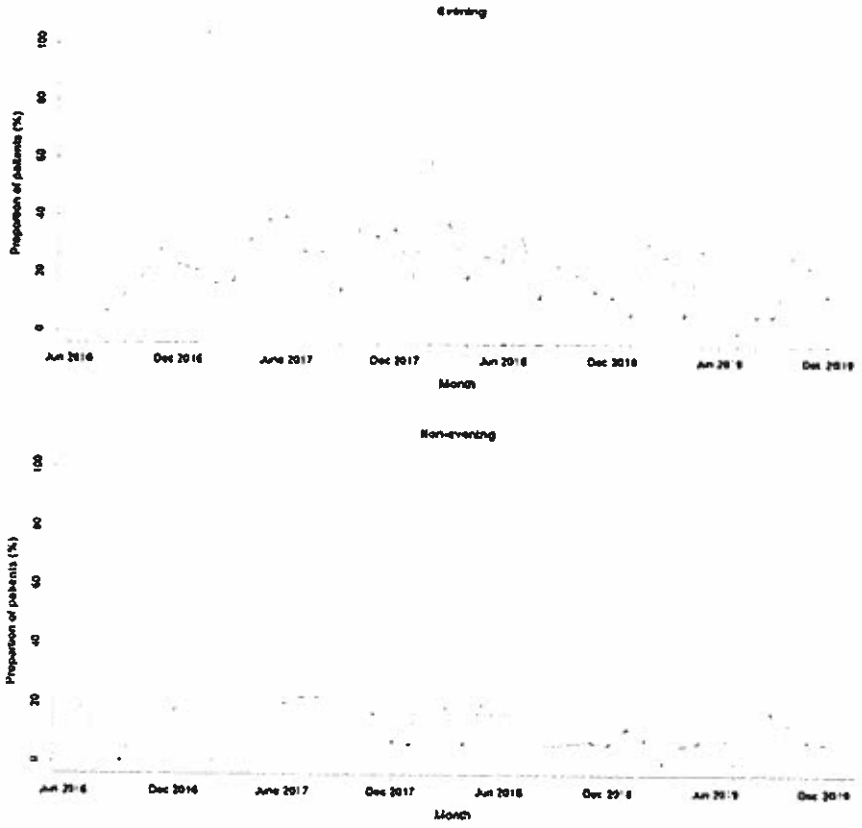

Fig. 4 Proportion of patients self-harming at baseline and post intervention split by evening and non-evening period. The figure shows the proportion of patients self-harming per month between 1st June 2016 and 31st November 2019 after removing outliers. Evening refers to 3-11pm and non-evening period refers to any time of day excluding 3-11pm. The intervention was introduced on 1st June 2018 indicated by the vertical time. The solid red line indicates the segmented regression analysis conducted at baseline and at post-intervention. The red dashed line indicates the counterfactual scenario (i.e. projected proportion of patients self-harming if the intervention had not been conducted). The intervention therefore achieved its main effect during the evening periods

self-harm incidents occurring on the ward, and similar rates have been reported on adult psychiatric settings [32–34]. An evening-focused intervention was designed with two main components; introducing a regular nursing shift between 3 and 11 pm, and implementing a structured activity programme for weekday evenings. An interrupted time series analysis was conducted to assess the longitudinal effects of the intervention on self-harm in young people. The rate of self-harm was declining at baseline and continued to decline following the intervention, but the rate of decline after the intervention was not significantly different to baseline. Nevertheless, the proportion of adolescents self-harming did significantly reduce following the intervention compared to baseline, even when two patients with numerous self-harm incidents were included in the analysis. The reduction was significantly larger in the evenings compared to the day, indicating that the evening-based interventions were driving the effects. This finding is both important from a therapeutic standpoint for patients and for clinical wards where resources are typically overstretched.

Previous interventions that have made environmental changes to adolescent inpatient settings have either focused on long-term systemic changes with staff training as a main component [51, 52] or have made immediate changes on the ward alongside introducing psychosocial therapies [43, 44]. This includes a recent study which introduced leisure activities for patients on the inpatient ward similar to those introduced in the present study, but in conjunction with an extensive DBT programme [44]. The study found that self-harming behaviour and suicide attempts decreased following the intervention, but a decline in the number of patients self-harming was not reported. It was also not possible to determine the impact of environmental changes on self-harm incidents [44]. The current study goes beyond these studies in showing that immediate environmental changes can reduce the number of adolescent inpatients who self-harm with and without suicidal intent on the ward.

A number of underlying mechanisms and functions of self-harm influenced by the intervention could have led to a reduction in young people self-harming on the ward. Availability of an additional nursing staff at a risky time on the ward could make it easier for nurses to intervene when adolescents begin to show early warning signs of distress [28]. This benefit is likely associated with the availability of nursing staff that have an ongoing relationship with young people on the ward instead of temporary staff that may come on the ward occasionally [28]. In the current intervention, the twilight shifts began to be increasingly filled by regular staff members and this may have led to a reduction in young people self-harming. It is plausible that increased visibility of staff may also reduce anxiety for patients on the ward and, therefore, reduce the likelihood that self-harm is used as a method to seek help. This is supported by the role of interpersonal functions of self-harm [3–5], as well as studies which find that self-harm and other harmful behaviours occur most often in the absence of regular staff [34, 64] and can be reduced by increasing staff visibility on corridors [65]. Clinicians in our study reported that an additional member of staff in the evening helped to alleviate stress, suggesting that presence of more staff helps to improve the general ward atmosphere.

Another component of the intervention was introducing a structured activity programme in the evenings. Since evenings are generally unstructured times of the day on psychiatric wards, some patients may find themselves feeling vulnerable and emotionally distressed during this time and using self-harm as a coping mechanism to regulate negative emotions such as feelings of pain and anger [3, 4, 33, 34, 48, 66]. Meaningful activities in the evening have been suggested as a positive way to distract patients who have negative thoughts and feelings [33, 47, 48, 67], and may help to replace the positive functions associated with self-harm with or without suicidal intent such as sensation-seeking and feelings of gratification [4]. Self-harm is also a private act in young people [36], and evening activities could delay patients from retreating early to their bedrooms, where they are likely to engage in self-harming behaviours alone or behaviours such as brooding which are indicative of suicidal behaviours [32, 48]. Patients admitted on psychiatric wards also report feelings of isolation, restriction and loneliness, and activities offered on the ward may foster positive relationships with other inpatients on the ward and feelings of group cohesion [36, 47], which can likely reduce feelings of isolation for young people and provide short-term relief. Another function of self-harm is the need to form relationship with peers through this behaviour [5, 35], and this is particularly important when adolescents are confined to an inpatient setting. Social activities can help replace this function of self-harm by offering a safe space for inpatients to bond and interact with others on the ward. However, distraction is not always beneficial for adolescents who engage in self-harm [34, 68], perhaps because adolescents may only want to be distracted by activities they enjoy. The fact that less young people self-harmed in the present study could be because patients on the ward were involved in decisions about the evening activity programme before these were introduced on the ward and, therefore, were more likely to engage with these activities. However, the intervention did not have an impact on the most vulnerable patients who self-harmed repeatedly as evident by the outliers. This supports the need for a more cohesive programme of care for patients on psychiatric wards; interventions should attempt to provide both short-term relief from distress by improving the ward environment in conjunction with long-term therapeutic care to reduce self-harm for all adolescent patients.

The value of an interrupted time series analysis

The current study demonstrates that an interrupted time series method can be used to rigorously evaluate interventions that improve healthcare systems over time when randomisation is not possible [55, 59–61]. Specifically, an interrupted time series analysis can account for any trends that may have existed before the intervention was introduced which is not always possible to detect in a simple pre-post analysis [55, 59, 60]. This is highlighted by our findings, where rates of self-harm did not significantly reduce following the intervention, as the rate of self-harm was already declining on the ward in 2 years preceding the intervention. Better analytical and research techniques have been advocated for interventions that attempt to improve complex healthcare services and systems [44, 69] and an interrupted time series is one approach which should be considered when evaluating health systems interventions over time.

Limitations and future work

The current findings should be interpreted in light of the limitations of implementing and evaluating this intervention. First, it was not possible to determine which intervention component contributed to a reduction in self-harming behaviour in young people. Despite introducing the structured activity programme after the twilight shifts had been embedded into practice, the time between these interventions was not sufficient to be analysed separately using an interrupted time series analysis. Second, while all patients were diagnosed by one psychiatrist using a standard clinical assessment, no validated diagnostic interview was used. This could make it difficult to compare diagnoses of patients in the current study with patients from other interventions. In addition, two patients self-harmed on the ward several times repeatedly during the study period and were considered outliers for the purpose of analysis. However, it was not clear whether the high rate of self-harm in these patients was due to individual factors or other aspects of the ward. Further work is still needed to reduce self-harm in high-risk adolescents on psychiatric wards. It was also not possible to determine whether the intervention reduced the number of people self-harming with or without suicidal intent, as intention was not reported in routinely collected incident data. It is likely, however, that the intervention had an impact on both types of self-harming behaviour, given that non-suicidal self-harm and self-harm with suicidal intent often co-occur and are closely related [7, 26, 70]. We recommend that in the future UK healthcare organisations should be encouraged to state the intent of self-harm when reporting these patient incidents, as this will be informative both for clinical teams and when reporting these incidents more widely. Another limitation is that the mechanisms of the intervention could only be inferred based on a limited understanding of the contributory factors of a psychiatric ward environment on adolescent self-harming behaviour. More research is needed so that interventions can be developed and targeted more effectively. It was also not possible to determine whether self-harm was influenced by how the intervention was implemented on the ward, such as what the staff did during the evening shifts, the type of activities that were conducted and even which inpatients took part in these activities. The aim of the intervention, however, was to identify the main intervention components which could be implemented and adapted based on the local context. Conducting an interrupted time series analysis further helped to minimise any impact on self-harm due to daily fluctuations on the ward and helped demonstrate the broader impact of the intervention over time.

Conclusion

Increased staff availability and introducing a structured activity programme during evenings on an adolescent psychiatric ward helped to reduce the proportion of young people who self-harm. This is an important finding both from a therapeutic standpoint and for overstretched healthcare services, where support can be provided to the most vulnerable patients. The study shows that in mental health, as in other safety–critical settings, changes to the environment and the organisation of care should be considered alongside direct therapeutic interventions when seeking to improve patient safety. An interrupted time series analysis should also be considered when evaluating interventions to health systems over time.

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Availability of data Due to sensitive patient information, data will not be made publicly available.

Compliance with ethical standards

Conflicts of interest The authors have no conflict of interest to declare.

Ethical approval The study was primarily aimed at improving a healthcare service, and therefore, a formal research ethics application was not required.

Code availability Code from R software will be available upon request.

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Commonwealth of Virginia

Department of Behavioral Health and Developmental Services

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Memorandum

Date: October 21, 2022

To: State Human Rights Committee

From: Brandi P. Justice, Psy.D., CSH Facility Director, Licensed Clinical Psychologist

Re: CSH Response to Public Comment on the Maximum Security Variance Renewal Requests

Thank you for providing Central State Hospital (CSH) the opportunity to submit written feedback to the public comments regarding our request to renew the Maximum Security variances. As so eloquently stated by Ms. Goldman during the September 29, 2022 State Human Rights Committee (SHRC) meeting, a variance is not a removal of one's human rights, but rather a different way of ensuring one's rights are protected. Our variances explain in depth the rationale for our requests, so I will not repeat them here. Rather, I will use this time to respond directly to the written public comments.

CSH is committed to ensuring patients are able to advocate and educate for one another on the human rights regulations and processes. We must balance that commitment with our responsibility to ensure a safe environment for everyone in our care. Patients have several methods by which to support one another, to include during special activities and on the treatment mall. Limiting the ability to communicate by phone will not interfere with these other opportunities to provide advocacy and education to one another.

Self-injurious behavior (SIB) has more than one etiology, to include a history of trauma, current psychosis, and/or self-stimulation related to a developmental disability. The treatment provided is dependent upon the etiology. In terms of the treatment provided at CSH for individuals experiencing SIB secondary to trauma, we offer several evidenced-based interventions to include Dialectical Behavior Therapy, Cognitive Behavior Therapy, and Seeking Safety. I can find no connection in the literature between the variances we are requesting and an increase in SIB, regardless of the etiology. It is also important to note that our rate of SIB is higher in our civil program where we do not have any variances.

CSH is committed to providing services from a recovery-oriented and trauma-informed perspective, which includes ensuring the physical and psychological safety of the individuals we serve. The requested variances do not interfere with our ability to provide services within this framework, but rather help support our ability to do so.

Virginia Center for Behavioral Rehabilitation
Facility Instruction No. 131
Criminal Incident Response and Filing Criminal Charges Against Residents

Date Issued: 1/2/13	**Page No.: 1 of 5**
Effective Date: 1/2/13	**Distribution List: VCBR Employees & Residents**
Review Date: 4/1/17	
Primary Reviewer: Chief of Security	**Secondary Reviewer: Policy Review Committee**
Attachments & Forms:	**Approved:** Jason Wilson Facility Director

Purpose: To establish guidelines for appropriate response during potential criminal acts committed by a resident or group of residents and provide guidelines to follow when considering filing criminal charges against a resident. This Instruction addresses only alleged criminal acts committed by individuals while residing at VCBR, it is not intended to address any prior criminal act that an employee may become aware of in the course of providing services to the individual.

Policy: VCBR staff shall respond appropriately to any criminal act in an attempt to preserve public safety and maintain a therapeutic environment at the facility.

Definitions: §18.2-8 Felonies, misdemeanors and traffic infractions defined: Offenses are either felonies or misdemeanors. Such offenses as are punishable with death or confinement in a state correctional facility are felonies; all other offenses are misdemeanors. Traffic infractions are violations of public order as defined in §46.2-100 and not deemed to be criminal in nature.

Authorized Representative: This means a person permitted by §37.2-401 of the Code of Virginia and 12VAC35-115-30 to authorize the disclosure of information and consent to treatment and services, including medical treatment and participation in human research. The term authorized representative is recognized by the Office of Attorney General as being either an AR or a legal guardian appointed under §54.1-2983 of the Code of Virginia.

Employee: Any state facility classified, non-classified, probationary, wage (hourly, WE 14), or contract employee.

ERT: Emergency Response Team

Individual: A person receiving services from VCBR.
Incident Command Structure: Based on the order below, the highest ranking staff on site shall be the Incident Commander in response to a possible criminal incident:

1) Facility Director
2) Chief of Security
3) Administrator of the Week
4) Security Supervisor

When a higher ranking staff member comes to the facility after a possible criminal act has been committed; the higher ranking staff member shall take over as the Incident Commander. When command is transferred, the current Incident Commander shall provide a verbal briefing of the possible criminal act to the assuming Incident Commander.

Reporting to Law Enforcement:

Any acts by individuals receiving services that could potentially result in criminal charges shall be evaluated on a case by case basis to determine the level of seriousness and if the behavior would be best addressed through clinical interventions as articulated in the individual's treatment plan or through referral to law enforcement or coordination with the Commonwealth's Attorney for disposition.

Even in situations in which it is believed that the individual may not be well served by the criminal justice system, alleged offenses of a serious nature may require a formal disposition by the criminal justice system.

In all instances, acts (other than treats to harm others which are the product of the individual's mental illness and which are of low probability to be carried out and are likely to resolve with care/treatment) that would constitute a felony if convicted shall be referred to law enforcement. Acts that would constitute a misdemeanor if convicted may be reported to law enforcement at the facility director's discretion. Consideration shall include whether the alleged criminal act was a result of the individual's mental health or functioning level or related to his reason for hospitalization, or whether the alleged criminal act appears unrelated to these things.

As the Facility Director's designee, the Chief of Security shall coordinate the referral of acts that would constitute a felony to law enforcement.

At the Facility Director's discretion, the Chief of Security shall investigate acts that would constitute a misdemeanor if convicted and, at the Director's discretion, report such acts to law enforcement. Prior to notification of law enforcement, the resident's Treatment Team shall be consulted to determine if the criminal act was a result of the individual's mental health or functioning level or related to his reason for hospitalization, or whether the alleged criminal act appears unrelated to these things.

Criminal Activity towards Staff:

While working at VCBR, employees are likely to be faced at some point in time with threatening or potentially violent behavior. Employees should make every reasonable effort to understand the motivation, functions, and precipitants of an individual's behavior.

Employees have the right to independently file charges against any individual receiving services. However, employees are encouraged to first consult with the facility director and treatment team of the individual prior to filing charges. Any employee who files charges against an individual who is receiving services in a facility MUST immediately report to the Facility Director that charges were filed regardless of whether the facility supported or did not support the filing of the charges.

VCBR is in no way bound to assist an individual employee in filing charges when doing so is in contradiction to the recommendations of the facility professional staff, although employees must comply with all lawful subpoenas and court orders that may occur as a result.

Any employee who chooses to file charges against an individual, whether this is with or without the facility's support, must comply with state and federal law and Departmental Instruction 1001 (PHI) 03, Policies and Procedures for the Use and Disclosure of Protected Health Information which defines expectations for professionals and facility staff in protecting the identifying information relevant to individuals served.

Employees may share only information that is necessary to address the specific alleged offense and provide evidence that a crime occurred at the facility with authorities. Information related to the individual's diagnosis, history, and treatment shall not be shared.

Criminal Activity Towards Peers

As the Director's designee, the Chief of Security shall assure the investigation of peer-to-peer acts of aggression and make any necessary referrals to law-enforcement as given in this instruction.

Acts of aggression resulting from potential staff neglect shall be investigated In accordance with Departmental Instruction 201 and Facility Instruction 208.

If one individual is the victim of alleged criminal activity resulting from a peer-to-peer act, the Chief of Security or designee shall notify the human rights advocate and, is applicable the victims AR.

Individuals who are the victims of a crime resulting from a peer-to-peer act at the facility must be given the opportunity to report the crime to law enforcement if they choose.

Procedures for Filing Charges

The following procedure shall be followed when criminal charges are filed against an individual:

- The employee who files the charges shall immediately notify the Facility Director and Chief of Security that criminal charges have been filed. The Facility Director and Chief of Security also shall be notified of peer-to-peer charges when staff becomes aware of them.
- The Chief of Security, having been apprised on the incident, shall notify the human rights advocate of the incident to ensure the individual's rights are protected during any investigations conducted and subsequent court proceedings.
- The Chief of Security, in consultation with the resident's Treatment Team shall ensure that the accused individual's AR, if applicable and any identified support persons or guardians are given appropriate and timely notification of the incident and of any charges filed against the individual.
- The Chief of Security shall notify the Risk Manager and the Risk Manager shall assure the Deputy Commissioner and relevant assistant commissioners are kept updated regarding the determination of the Commonwealth's Attorney, subpoenas, and requests for information, relevant court dates, and any relevant updates communicated regarding the criminal investigation via media alerts or other written or electronic communications.
- The Facility Director and Chief of Security shall ensure, when notified of any court proceedings, that a facility representative is present at all legal proceedings pertaining to the alleged event and that appropriate facility and central office staff members are kept advised of all developments in the proceedings.

Communication of SVP Status:

Prior to the transport of an individual to local jail awaiting trial or to court proceedings, the Chief of Security shall assure the sheriff is informed that the individual charged has been committed to the Commissioner's custody as a Sexually Violent Predator (SVP).

It should be made clear that the individual who has been civilly committed to the custody of the Commissioner under the SVP statues may only be released back to VCBR.

If Individual is Found Guilty:

If the placement of charges against an individual result in his incarceration, relevant treatment and medical information shall be communicated to the correctional facility or regional jail the individual is remanded to.

The attending physician shall:

- Discharge the individual to the jail or correctional facility
- Assure the jail or correctional facility is informed of the individual's current clinical status, treatment needs, AR or other contact persons; and
- Provide a current medication list to the jail or correctional facility personnel to whom the individual will be discharged.

Data Collection:

The Risk Manager shall track and analyze all incidents involving alleged criminal activity by individuals and report to the Department's Assistant Commissioner for Behavioral Health and Assistant Commissioner for Quality Management and Development annually, by June of each year.

Resident Safety and Security

During the course of investigation of an incident, investigating staff shall take necessary precautions to assure the protection of the resident.

- A resident claiming fear of retaliation from other residents may be provided Special Precaution/Observation status (e.g., 1:1, Q15, etc.) upon the recommendation and order of a physician. The physician shall consult with the resident's treatment team and individual performing the investigation when making this determination.
- Interviews of residents shall occur in a location which would prevent other residents from knowing of the interview. Any necessary statements from residents shall be taken in a location which would prevent other residents from knowing of the interview.

References:

Departmental Instruction 205 Filing Criminal Charges Against Individuals Served in State Facilities.

Issued: 10/1/89
Revised: 7/2/2012
Reviewed: 10/01/17

Departmental Instruction 205 (RTS)89
Filing Criminal Charges Against Individuals Served in State Facilities

205 - 1 Background

Individuals served in facilities operated by the Department of Behavioral Health and Developmental Services ("Department") generally possess the same legal rights and responsibilities as citizens residing in the community. Any allegations of criminal activity committed by individuals residing or being served in facilities operated by the Department (state facilities) must be dealt with in a consistent manner, while protecting the interests of the alleged perpetrator and victim.

205 - 2 Purpose

This Departmental Instruction (Instruction) provides guidelines to follow when considering filing criminal charges against an individual served in a state facility. It is meant to address only alleged criminal acts committed by individuals while in the custody of the Commissioner or while residing in a state facility. It is not intended to address any prior criminal act that an employee may become aware of in the course of providing services to the individual.

205 - 3 Definitions

The following definitions shall apply to this Instruction:

Authorized representative (AR) This means a person permitted by §37.2-401 of the Code of Virginia and 12VAC35-115-30 to authorize the disclosure of information and consent to treatment and services, including medical treatment, and participation in human research. The term authorized representative is recognized by the Office of the Attorney General as being either an AR or a legal guardian appointed under §54.1-2983 of the Code of Virginia

Individual This means a person who is receiving services..

Employee This means any state facility classified, non-classified, probationary, wage (hourly, WE 14), or contract employee.

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205 - 4 Responsible Authorities

Central office

The Assistant Commissioner for Behavioral Health is responsible for interpretation of this Departmental Instruction.

Facilities

Facility directors are responsible for ensuring that procedures are established to comply with this Instruction, including a process for training all employees on the procedures in this Instruction.

205 - 5 Specific Guidance

Reporting to law enforcement

Any acts by individuals receiving services at a Department facility that could potentially result in criminal charges shall be evaluated on a case by case basis to determine the level of seriousness and if the behavior would be best addressed through clinical interventions as articulated in the individual's treatment, recovery, or services plan; or through referral by the facility director to law enforcement, who will then coordinate with the Commonwealth's Attorney for disposition.

Even in situations in which it is believed that the individual may not be well served by the criminal justice system, alleged offenses of a serious nature may require a formal disposition by the criminal justice system.

In all instances, acts (other than threats to harm others which are the product of the individual's mental illness and which are of low probability to be carried out and are likely to resolve with care/treatment) that would constitute a felony if convicted shall be referred to law enforcement by the facility director. Acts that would constitute a misdemeanor if convicted may be reported to law enforcement at the facility director's discretion.

Considerations shall include whether the alleged criminal act was a result of the individual's mental health or functioning level or related to his reason for hospitalization, or whether the alleged criminal act appears unrelated to these things.

The facility director, in consultation with the facility clinical staff, shall prepare the individual for potential disposition regardless of the mental state, clinical condition, or functional level of the individual alleged to have committed the alleged crime. The facility shall cooperate with law enforcement throughout the process if criminal charges are pursued.

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Mitigation of risk

If it is determined that the alleged criminal behavior is in any way likely to be repeated or that individuals employed by or residing at the facility are at any heightened risk, the facility director shall take all reasonable measures to mitigate this risk and help ensure the safety of those individuals.

Criminal activity towards staff

While working in any state facility, whether it serves individuals with behavioral health or intellectual/developmental challenges, employees are likely to be faced at some point in time with threatening or potentially violent behavior. State facility employees should make every reasonable effort to understand the motivation, functions, and precipitants of an individual's behavior.

Individual employees have the right to independently file charges against any individual receiving services in a state facility. However, employees are encouraged to first consult with the facility director and clinical teams within their facility. Any employee who files charges against an individual who is receiving services in a facility MUST immediately report to the facility director that charges were filed regardless of whether the facility supported or did not support the filing of the charges.

State facilities are in no way bound to assist an individual employee in filing charges when doing so is in contradiction to the recommendations of the facility professional staff, although employees must comply with all lawful subpoenas and court orders that may occur as a result.

Any employee who chooses to file charges against an individual, whether this is with or without the facility's support, must comply with state and federal law and Departmental Instruction 1001 (PHI) 03, *Policies and Procedures for the Use and Disclosure of Protected Health Information*, which clearly defines expectations for professionals and facility staff in protecting identifying information relevant to individuals served in state facilities.

State facility employees may share only information that is necessary to address the specific alleged offense and provide evidence that a crime occurred at the facility with authorities. Information related to the individual's diagnosis, history, and treatment shall not be shared.

Criminal activity towards peers

Each state facility must have a policy for investigating peer-to-peer acts of aggression. If one individual is the victim of alleged criminal activity resulting from a peer-to-peer act, the human rights advocate and the victim's AR, if applicable, shall be promptly notified. Individuals who are the victims of a crime resulting from a peer-to-peer act at the facility must be given the opportunity to report the crime to law enforcement if they choose.

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205 - 6 Procedures

Procedures for filing charges

The following procedures shall be followed when criminal charges are filed against an individual who is receiving services in a state facility:

- The employee who files the charges shall immediately notify the facility director that criminal charges have been filed. The facility director also shall be notified of peer-to-peer changes when staff becomes aware of them.
- The facility director, having been apprised on the incident, shall notify the human rights advocate of the incident to ensure that the individual's rights are protected during any investigations conducted and subsequent court proceedings.
- The facility director shall ensure that the accused individual's AR, if applicable and any identified support persons or guardians are given appropriate and timely notification of the incident and of any charges filed against the individual.
- The facility director will ensure that full facility cooperation is given to any investigation into the situation or alleged incident, within the parameters of applicable laws and consistent with HIPAA and Departmental Instruction 1001 (PHI) 03.
- If there are reviews or investigations related to the incident, the relevant assistant commissioner or his designee and the Office of the Attorney General shall be consulted and kept updated on any relevant findings as needed.
- The Deputy Commissioner and relevant assistant commissioners shall be kept updated regarding the determination of the Commonwealth's Attorney and any relevant updates communicated regarding the criminal investigation via media alerts or other written or electronic communications.
- The Deputy Commissioner and relevant assistant commissioner of the Department shall be kept informed of any subpoenas, requests for information, and any relevant court dates via media alerts or other written or electronic communications.
- The facility director shall ensure, when notified of any court proceedings, that a facility representative is present at all legal proceedings pertaining to the alleged event and that appropriate facility and central office staff members are kept advised of all developments in the proceedings.
- If the placement of charges against an individual results in his or her incarceration, the facility director shall ensure all reasonable attempts are

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Procedures for filing charges *(continued)*

made by the current treatment team to coordinate discharge planning with both the local community services board (CSB) and the correctional facility's mental health staff. If there is a regional jail team providing services to that correctional facility, that team also shall be advised of the circumstances of the individual's discharge and any clinical needs.

Individuals on forensic status

Not Guilty by Reason of Insanity (NGRI) acquittees: If an NGRI acquittee is charged and transferred to a jail or correctional facility, the forensic coordinator shall:

- Inform the sheriff or correctional facility director of the individual's NGRI status and that the individual is committed to the custody of the Commissioner;
- Provide a copy of the most recent commitment order showing the Commissioner's authority/responsibility to detain the individual; and
- Notify the NGRI court, Commonwealth Attorney, and defense attorney and the CSB NGRI coordinator of the individual's status and location.

The sheriff or correctional facility director shall be informed that upon release, the individual must be returned to a state facility and that the state facility MUST be notified immediately if the individual posts bond in order to enable a rapid readmission to the referring facility. Upon such notification, the facility shall notify the relevant assistant commissioner or designee and CSB contact.

If readmission to a different state facility is indicated upon release from the correctional facility, the original facility shall coordinate and facilitate that admission. It may also be necessary for the original facility to admit the individual on a temporary basis until a transfer can be safely arranged.

If the individual is found guilty of the charges while hospitalized at a state facility, the individual's attending physician shall:

- Discharge the individual to the jail or correctional facility;
- Inform jail or correctional facility personnel of the individual's legal status, current clinical status, treatment needs, AR or other contact persons, and the CSB staff contact; and
- Provide a current medication list to the jail or correctional facility personnel and CSB staff contact.

As the Department retains some responsibility for the health and welfare of the NGRI acquittee because the individual is still committed to the Department's custody, facility staff shall avail themselves as needed to jail or correctional facility personnel to provide clinical consultation to enhance continuity of care.

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Individuals on forensic status *(continued)*

Sexually Violent Predator (SVP) status: If the individual charged has been committed to the Commissioner's custody under the SVP statutes; or is on conditional release as a SVP; the sheriff shall be informed of this fact prior to transport.

It should be made clear that the individual who has been civilly committed to the custody of the Commissioner under the SVP statutes may only be released back to the state facility from which he or she came.

If the individual is found guilty of charges, the facility attending physician shall:

- Discharge the individual to the jail or correctional facility;
- Inform jail or correctional facility personnel of the individual's current clinical status, treatment needs, AR or other contact persons, and the CSB staff contact, if any; and
- Provide a current medication list to the jail or correctional facility personnel to whom the individual will be discharged.

Other Forensic Status: If an individual who has been admitted to a state facility under a forensic status (§19.2-169.1, §19.2-169.2, §19.2-169.5, or 1§9.2-169.6) is arrested and jailed on new legal charges stemming from his or her behavior or actions in the facility, the facility forensic coordinator shall:

- Inform the sheriff or correctional facility director of the individual's forensic status and that he or she is committed to the custody of the Commissioner;
- Provide a copy of the most recent commitment order showing the Commissioner's authority/responsibility to detain the individual; and
- Notify the court of jurisdiction for the original charge, the Commonwealth Attorney for the original charge, and the defense attorney for the original charge.

The sheriff or correctional facility director also shall be told that upon release, the individual must be returned to a state facility unless the individual's primary forensic issue has already been resolved – e.g. the report regarding the individual's competency/sanity has been completed.

If the individual is found guilty of the charges while hospitalized at a state facility, the individual's attending physician shall:

- Discharge the individual to the jail or correctional facility;
- Inform jail or correctional facility personnel of the individual's legal status, current clinical status, treatment needs, AR or other contact persons, and the CSB staff contact; and
- Provide a current medication list to the jail or correctional facility personnel and CSB contact.

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Mandatory data collection

Each facility risk manager shall track and analyze all incidents involving alleged criminal activity by individuals while residing or being served in the facility, and shall submit a report to the Department Assistant Commissioner for Behavioral Health and Assistant Commissioner for Quality Management and Development containing information by June of each year.

205 - 10 References

- HIPAA Privacy Rule, 45 C.F.R. Part 160 and Subparts A and E of Part 164
- Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the [Department of Behavioral Health and Developmental Services], 12 VAC 35-115-et seq.
- Departmental Instruction 1001(PHI)03, *Privacy Policies and Procedures for the Use and Disclosure of Protected Health Information*

James W. Stewart, III
Commissioner

Effective Date: July 2, 2012

Summary of Violation Letters for State Facilities
Office of Human Rights

September 2022

The purpose of the Violation Letter is to document the manner in which state operated facilities acknowledge Human Rights violation(s), and identify and implement appropriate corrective action(s), in accordance with timelines outlined in the Human Rights regulations. The work of correcting, mitigating and preventing abuse occurs after the identification of the violation. The assurance of this work is the responsibility of the Facility Advocate [12VAC35-115-260] and is reflected in the substance of the Violation Letter process.

During August 2022, there were 10 violation letters issued across the 12 state facilities. All 10 violation letters were related to the Abuse and Neglect Investigation Process (DI 201). CCCA returned their corrective action plan one day late and all others were received on-time.

Compiled by Brandon Charles, MSW, Facility Advocate Manager

FACILITY SECLUSION AND RESTRAINT REPORT

OFFICE OF HUMAN RIGHTS

DBHDS Facility: VA Center for Behavioral Rehabilitation (VCBR)

Reporting Period: September 2022

Advocate : Tony Davis

Region: 4

Seclusion & Restraint:

There were four Physical restraints and one mechanical restraint, with no injuries, and no reports of seclusion.

Restraint Type:	September *Census-In-House: 374*
Physical	4
Ambulatory	0
Non-ambulatory	1
Pharmacologic	0
TOTAL:	5

Transport Restraints	151
Seclusion	0

During the month of September, there were a total of 151 transport restraints. The shortest duration of these restraints was one hour 11 minutes, and the longest duration was 10 hours 35 minutes (ER Visit). The overall time for transport restraints was 648 hours 29 minutes. In comparison to August's report, there was an increase of transport restraints due to scheduled community appointments resulting in a difference of 180 hours and 13 minutes.

Allegations of Abuse and Neglect:

There were three abuse allegations reported this period – all were verbal and all were unsubstantiated.

Abuse/Neglect Category:	September
Physical	0
Restraint	0
Verbal	3
Neglect (non peer-to-peer)	0
Neglect (peer-to-peer)	0
TOTAL:	3

Human Rights Complaints:

There were 26 human rights complaints, and of those were 24 Dignity complaints, and eight were substantiated violations. The two complaints of Access to Services Record were unsubstantiated. The substantiated cases of Dignity range from discussing a resident's discharge plan in front of peers and a potential landlord during a community outing, to not receiving a response to GTL requests, to not having a lockable door, and a medicine change without prior knowledge or input.

Complaint Category:	September
Assurance of Rights	0
Dignity	24
Services	2
Complaint Review Process	0
Restrictions	0
TOTALS:	26

Policy Updates & Facility Initiatives:

There were no policy updates or initiatives that affect human rights this period.

Compliance:

There were no violation letters issued for cases reported during this period.

LHRC APPLICATION FORM

NAME OF LHRC: Choose an item.

Today's Date:

First and Last Name: Email address:

Street Address:

City, State*, Zip: Telephone #:

*If you live in a state bordering Virginia, please explain your affiliation with the Virginia Behavioral Health system:

Current (or most recent) Employer:

Employer's Address:

Dates of Employment: From ____/____/____ to ____/____/____

Occupation/ Profession (if retired, list previous occupation):

Educational Background:

Please check categories in which you are eligible and willing to serve:

Family Member ___ Individual ___ Healthcare Provider ___ Other Professional ___

Family Member means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services.

Individual means a person who is currently receiving mental health, developmental or substance use treatment or services, or who has received services within the last 5 years.

Healthcare Provider means a person who is currently employed by an entity or organization offering services licensed, funded, or operated by the Department of Behavioral Health and Developmental Services, including all persons who are licensed, certified, or registered by any of the health regulatory boards within the Department of Health Professions, except the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

Other Professional shall include lawyers, teachers and other persons with interest or knowledge or training in the treatment of mental illness, developmental intellectual disabilities and or substance use disorders.

LHRC APPLICATION FORM (CONTINUED)

Have you ever been employed by, or a member of, the board of directors for a Community Services Board or Behavioral Health Authority? Yes_____ No____

If Yes, name of program (or programs):

Capacity in which you served:

Dates of service: From ____/_____/_____ to _____/_____/_____

Have you ever been a volunteer of a program operated by the Department of Behavioral Health and Developmental Disabilities? Yes_____ No____

Dates of service: From ____/_____/_____ to _____/_____/_____

Please describe your education, training, and/or experience in the areas of Mental Health, Developmental/Intellectual Disabilities and Substance Use Disorder Services:

What is your interest in serving on a Local Human Rights Committee?

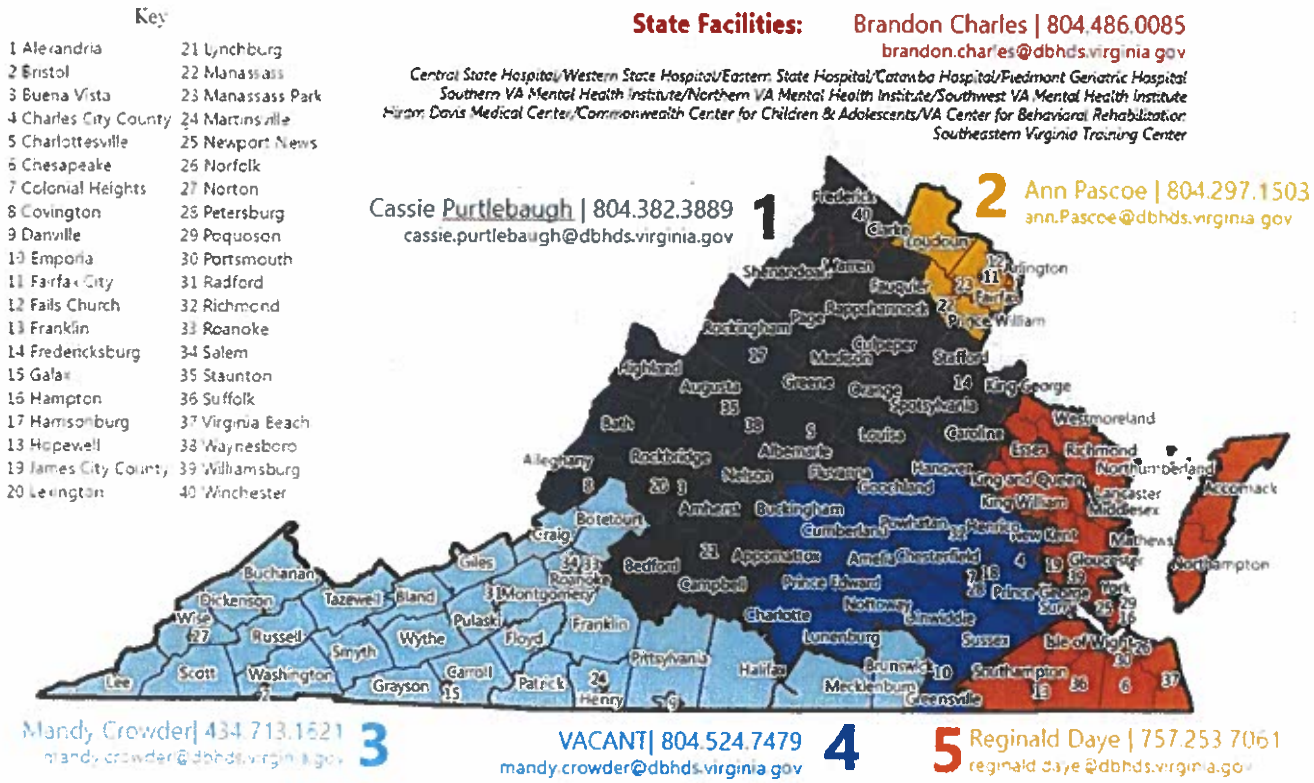
As a member of the Local Human Rights Committee and based on your understanding of this Committee's meeting schedule, how will you ensure physical attendance at all required meetings and (virtual) participation in all required training sessions?

Please provide any additional information you think is relevant to your application.

Applicant's Signature:

Signature of OHR Reviewer:

Thank you for your interest in serving on a Local Human Rights Committee. Please return completed applications to the Regional Manager in the area you wish to serve:



OHR Regional Manager Contact Information

Revised 10/2022

State Human Rights Committee

Department of Behavioral Health and Developmental Services

2023 Meeting Schedule

October 2022

Meeting Date	Agenda Deadline	*Appeal Deadline*	Region *Subject to change*	Location / Virtual Refer to Commonwealth Calendar for Details
January 19	January 4	*December 29*	Region 4 Central	
March 2	February 15	*February 9*	Region 2 Northern VA	
April 13	March 29	*March 23*	Region 3 Southwest	
May 18	May 2	*April 26*	Region 5 Tidewater	Smithfield or Surry (Southside)
June 22	June 7	*June 1*	Region 1 Northwest	
August 17	August 2	*July 27*	Region 5 Tidewater	
September 28	September 13	*September 7*	Region 2 Northern VA	
November 2	October 18	*October 12*	Region 4 Central	
December 7 Or Dec 14	November 21 *(Tuesday)*	*November 16*	Region 4 Central	

The SHRC is required to meet at least 8 times a year.
Unless special circumstances apply, administrative sessions normally convene at 8:30AM. Regular sessions normally convene at 9:00AM and run until all agenda items are addressed. Portions of meetings are held in closed session. Appeals are normally scheduled for late morning.